PHYSICIANS AND MEDICAL MALPRACTICE: WHY DO DOCTORS HAVE UNWARRANTED FEARS?

A Dissertation

by

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ABSTRACT

Physicians are concerned about medical malpractice. Research has shown that physicians remain concerned even when they practice in states that have enacted tort reform measures such as caps on non-economic damages.

To understand how doctors in a state with tort-reform (Texas) understood and dealt with their medical malpractice concerns, thirteen semi-structured interviews were conducted and analyzed (six obstetrics/gynecology physicians and seven internal medicine physicians). Research question one explored specifically how Texas doctors make sense of medical malpractice in Texas and their coping strategies. Coding and analysis revealed four dominant themes: 1) legal knowledge ("tort reform" and "legal system"); 2) personal risk assessment ("not worried vs. it's on my mind," "heightened concerns," and "out of my control"); 3) risk reduction techniques ("communication skills," "patient management skills," and "documentation skills"); and 4) coping mechanisms ("feeling insulated" and "admitting limitations").

The second research question asked physicians to identify sources that influenced their medical malpractice knowledge. They cited the following influences: 1) memorable personal experiences, 2) medical training and experience, 3) information from external organizations, 4) information from unspecified sources.

The study confirmed that the participants were still worried about medical malpractice even though they were practicing in state with tort reform. The study also demonstrated that the doctors' knowledge of medical malpractice came from their

personal experiences and word-of-mouth rather than any formal training or legal resources. The theoretical concepts of legal consciousness and sensemaking were combined in this study to determine how the doctors oriented themselves in relationship to the law and how they came to these positions. By using the theories of legal consciousness and sensemaking together, a contribution is made to current and future scholarship regarding understanding and mitigating doctors' concerns regarding medical malpractice.

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

"How many of you think you will be sued?" This question was posed in March 2013 to a group of fourth-year medical students in a professionalism course at the end of their medical school training. Every student raised a hand. As the instructor for the course, I was struck by the certainty in the students' faces. They were sure that some of the very people they were vowing to care for would sue them.

As discussed below, medical students and doctors alike are concerned that they will be sued. The students addressed above were completing their medical training in Texas, a state that has undergone highly-publicized tort reform (Swartz, 2005). However, the empirical research shows doctors are less likely to be sued than they think. In fact, when doctors are sued, the research shows that juries usually side with the doctors instead of the patient-plaintiffs who sue them. If doctors do lose or decide to settle a medical malpractice case, payouts are largely covered by their insurance companies, so their direct financial losses are minimal.

As I started researching the doctors' concerns, even those practicing in tort-reformed states, as well as the research surrounding medical malpractice, I was struck by the complexity of the medical malpractice landscape as well as the various terms employed by commentators in the malpractice discussion. I also will review the basics of malpractice insurance and tort reform, focusing on Texas because the participants in my study practice there.

Medical Malpractice Insurance & Tort Reform in Texas

Medical Malpractice Insurance

Many commentators posit that the 2003 Texas tort reform was needed due to a medical malpractice "crisis" (see Baker, 2005; Williams, 2012; Bayer, 2005). According to Bayer (2005), a medical malpractice crisis occurs when physicians' medical malpractice premiums are excessively high and that cost is passed along to "innocent bystanders" (p. 114, citing Eisenberg & Sieger, 2003). Bayer cites to Eisenberg and Sieger's assertion that insurance premiums "doubled" for the doctors highlighted in their *Time Magazine* article. The article focused on insurance companies increasing medical malpractice insurance rates or failing to renew policies altogether in Illinois citing a concern over rising jury awards in Illinois for the two preceding years.

However, what constitutes "excessively high" medical malpractice premiums for physicians is debatable. Baker (2005) explains that doctors in higher risk specialties might bear more of the burden for paying medical malpractice premiums. But Baker argues that the overall amount spent on medical malpractice is not "excessive." First, he explains that the amount that doctors and hospitals pay in premiums is far less than overall cost of the injuries they cause (citing Danzon, 1985).[1] Second, Baker points out that medical malpractice insurance expenditures are actually lower than other types of insurance expenses. He gives the following amounts for insurance premiums paid in 2003: $11.3 billion for medical malpractice; $142.4 billion for auto liability; and $56.9 billion for workers' compensation premiums (p. 63 citing to Best, 2004; Kohn, Corrigan,

[1] Evidence regarding the injuries caused by doctors and hospitals is reviewed in the next section.

& Donaldson, 2000).

The participants in this study rarely discussed malpractice insurance costs, but those who did took positions that were similar to the results of these studies. One recalled that premiums were higher before tort reform, but noted that his current medical malpractice insurance premiums are "trivial" compared to his other business operating costs. He made no mention of insurance premiums ever being overly burdensome.

Another participant who took an active role in the business expenses of his small, private practice did talk about having high premiums for a time right before tort reform. The year before tort reform in Texas, 2002, his practice saw a 92% increase in medical malpractice premiums (from $37,337 to $71,722). The following year, in 2003, the premium decreased 19%. Insurance premiums have continued to drop for his practice in the subsequent ten years. In 2013, the premium was $22,798, or 39% less than the amount the practice paid in 2001. He, too, indicated that premiums are no longer a significant consideration for his practice. Therefore, the term "excessively high" is certainly relative and communicatively-constructed.

Despite how insurance "crises" or "excessively high" insurance premiums are defined, researchers do generally agree that there were two so-called medical malpractice crises – one in the 1970's and another in the 1980's (Weiler et al., 1993, pp. 1–3; Baker, 2005, pp. 1–2). And Baker suggests that a third began in 2002 (also see Nelson, Morrisey, and Kilgore, 2007).[2] They cited to a Congressional Budget Office brief that stated, premiums for all physicians nationwide rose by 15 percent between

[2] This third "crisis" is also suggested by Eisenberg & Sieger (2003) and Paik, Black, and Hyman (2013a).

2000 and 2002—nearly twice as fast as total health care spending per person" (Congressional Budget Office, 2004, p. 1). The brief went on to note sharper increases in certain specialties, "22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons" (p. 1).

While "high" insurance premiums are cited as the underlying reason for tort reform, the insurance companies have blamed the higher malpractice insurance rates on an increased number of lawsuits and larger jury awards (Eisenberg & Sieger, 2003). There is evidence that insurance claims and payment amounts have increased over time, but there is no single data source to draw upon to determine the amount (Weiler et al., 1993). Weiler et al. (1993) did state that the number of insurance claims filed per doctor per year rose from one claim per 100 physicians in the 1950s to 10 claims per 100 physicians by the mid-1980s (p. 4). They also stated that the average payment for a successful claim in 1970 was 40,000 (adjusted to 1990s dollars), but by the end of the 1980s, the average payment had jumped to almost $150,000.[3]

Baker (2005) argued that even though lawsuits against physicians and insurance company payouts may have increased, malpractice premium increases are due to the "boom-and-bust cycle" in the insurance industry (p. 45). He included an "Insurance Accounting 101" in his book (pp. 48–50). According to Baker, medical malpractice insurance has a long time horizon from the time a doctor pays for his or her insurance until a claim is paid. In the interim, insurance companies invest the cash received as premiums and collect the profits from these investments. Insurance companies must also

[3] The authors made no reference to changes in plaintiff-patients' likelihood of success in these cases.

predict the amount of reserves they need to keep on hand in order to pay claims. In this dance of investing assets and holding reserves, insurance companies must make adjustments and report losses when they have miscalculated. When large losses must be reported, an insurance company's financial position can become dramatically worse.

Baker (2005) explained that insurance companies do raise medical malpractice premiums in order to replenish the reserves that have been depleted, but he argued that it is the uncertainty surrounding malpractice insurance and not large payouts that cause dramatic depletions (p. 48). First, the long time-horizon for medical claims makes it difficult for insurance companies to accurately predict losses year to year. Second, rapid advancements in medical care make it more difficult to estimate the cost for medical malpractice claims.

The actual reasons for the fluctuation in medical malpractice premiums are likely attributable to both the payments made by insurance companies to claimants and the returns insurance companies record on their investments. In fact, a 2004 Congressional Budget Office brief stated, "The available evidence suggests that premiums have risen both because insurance companies have faced increased costs to pay claims (from growth in malpractice awards) and because of reduced income from their investments and short-term factors in the insurance market." (p. 1). No matter the reasons causing medical malpractice insurance premiums to fluctuate, premium increases have been blamed for the three medical malpractice "crises."

Tort Reform in Texas

Now we turn back to tort reform in Texas.[4] I was in my last year of law school in Austin, Texas during the 2003 legislative session while tort reform was being hashed out in the Texas media. According to Conde (2007), the Texas Medical Association (TMA) and its partners helped pass tort reform in Texas. Before reviewing the actual reform, it is important to note the partners the TMA worked with: the Texas Alliance for Patient Access (TAPA), the Texas Hospital Association (THA), and county medical societies (Conde, 2007, p. 20). Interestingly, another partner in passing tort reform was an insurance company – Texas Medical Liability Trust (TMLT) that helped create the TAPA in 2002. All of these players had a voice in passing tort reform and could continue to influence how we think about medical malpractice.

Tort reform in Texas involved successfully passing two items in 2003 – House Bill 4 and Proposition 12. House Bill 4, which was later codified as section 74.301 in the Texas Civil Practices and Remedies Code, put a $250,000 cap on non-economic damages, such as "pain and suffering," in health care cases. Economic damages, such as hospital expenses and lost wages, were not subject to the cap. The cap could be increased up to $750,000 if multiple defendants were responsible for the same case (see TEX. CIV. PRAC. & REM. CODE ANN. § 74.301). In fact, some citizens thought the cap they were voting for was actually a "$750,000 cap" they had seen in advertisements

[4] Thirty-one (31) states have passed tort reform for medical malpractice cases that limits or "caps" noneconomic or total damages. Paik et al. (2013a) reviews the current state of tort reform nationwide including the reforms past in each state. The Paik et al. team estimates that 68% of the American population is covered by some type of damages caps. According to Becker (n.d.), the following states cap noneconomic damages at $250,000: Alaska, California, Idaho, Kansas, Montana, Ohio, Texas, and West Virginia.

(Swartz, 2005). Clearly, there were organizational rhetoric forces at work.

The other item necessary for tort reform to be effective in Texas was the passage of Proposition 12 which amended the Texas constitution to specifically make damages caps enforceable (Daniels & Martin, 2007; Tex. Const. Art. III, § 66). A 1988 Texas Supreme Court case (*Lucas v. United States*) had found that damages caps violated Article 1, section 13 of the Texas State Constitution: "All courts shall be open, and every person for an injury done him, in his lands, good, person or reputation, shall have remedy by due course of law." Proposition 12 allowed the Texas legislature to limit or "cap" damages in medical or health care cases. Both House Bill 4 and Proposition 12 were passed in September 2003.

Researchers have argued that tort reform has had positive effects for Texas physicians. Stewart et al. (2011) reported a "5-fold decrease in the risk of a malpractice lawsuit being filed" and a "significant decrease in the cost of medical malpractice lawsuits" after tort reform (pp. 465–466). Hyman and Silver (2013) similarly found that the total number of malpractice lawsuits in Texas fell from 7,650 to 5,300 immediately after the implementation of tort reform. Conde (2007) detailed reductions in medical malpractice premiums following tort reform. In fact, the company that insured more doctors in Texas than any other carrier at the time, Texas Medical Liability Trust (TMLT), lowered its rates several times following tort reform: "12 percent in 2004, 5 percent in 2005 and 2006, and 7.5 percent [in 2007]" (Conde, 2007, p. 20). And Stewart, West, Schirmer, and Sirinek (2013) found that the number of physicians practicing in Texas increased by 44% after tort reform, with a 46% in metropolitan areas and a 9%

increase in non-metropolitan areas. The researchers noted that the metropolitan areas grew more than the non-metropolitan areas (23% and 8%, respectively) during the time following tort reform. The researchers also studied population information regarding rural communities by evaluating the twenty-two Texas trauma service areas (TSAs) that cover the entire state of Texas. They found that for the TSAs, there was an increase in the following types of physicians: primary care increased 38%, obstetrics/gynecology increased 25%, and surgeons increased 26%.[5] Therefore, one would think that medical malpractice fears would be mitigated by tort reform. However, research to date shows that when surveyed, even Texas doctors report ongoing fears of medical malpractice (Carrier, Reschovsky, Mello, Mayrell, & Katz, 2010).

These findings beg the question: Why do doctors still have a fear of medical malpractice lawsuits despite evidence that should allay their fears?

I will examine the research to-date detailing the mindset doctors have regarding medical malpractice compared to the facts. I will then review explanations that have been offered for this mismatch in perception and reality, and I will suggest communication-based research that could be done to better understand doctors' mindsets about medical malpractice.

Medical Malpractice – The Facts

In *The Medical Malpractice Myth*, Baker (2005) reviewed study after study to "bust" the public myths about malpractice. Many points were made regarding the reality

[5] The increase these specialties is interesting when coupled with the data from Jena, Seabury, Lakdawalla, and Chandra's (2011) study regarding which specialties are most likely to be sued. Jena et al. (2011) conducted a nationwide review and found that surgeons are the most likely specialty to be sued and doctors practicing obstetrics and gynecology were similarly high-risk.

of medical malpractice. The research highlighted below focuses on three "facts" that should moderate doctors' fears regarding medical malpractice: (1) people who are injured by doctors do not always file lawsuits, (2) the legal system is operating well, and in the favor of doctors, and (3) insurance companies fight medical malpractice claims.

Injured People Do Not Always File Suit

Pursuing a lawsuit is difficult, even in states that have not enacted tort reform. As a former litigator, I have watched plaintiffs weep as they retold their story multiple times through the process. I have also seen injured plaintiffs refuse to get better in order to remain hurt for trial, which comes many years after the initial injury.

Sociological research has shown that the act of filing a lawsuit is difficult. Felstiner, Abel, and Sarat (1981) found that most people who believe their legal rights have been violated do not take any action, or if they do take action, they do not complete a formal lawsuit. Felstiner et al. identified several steps to filing a legal claim: (1) naming the problem or wrong, (2) blaming a third-party for the problem or wrong and (3) claiming some form of redress. The authors call each step a type of "transformation" on the path to turning an "unperceived injurious experience" to a "perceived injurious experience" (p. 633). The authors explained that all of these steps are influenced by social surroundings and expectations and that sometimes an outside force or person is necessary for a person to mobilize.

What type of patient files suit?

The type of patient that mobilizes and actually files a medical malpractice lawsuit has been studied. May and Stengel (1990) employed Felstiner et al.'s model to

identify what influences patients to sue or refrain from suing a doctor. May and Stengel interviewed 240 aggrieved patients – 175 that did not file a formal lawsuit and 65 that did file suit. The researchers classified all interviewees into one of five categories based upon the Felstiner et al. "transformation" points detailed above: (1) "lumpits" – those who took no action; (2) "claimers" – those who talked to their doctors about the issue; (3) "exiters" – those that avoided conflict by changing doctors; (4) "lawyer seekers" – those who contacted a lawyer; and (5) "formal suers" – those who filed a formal lawsuit.

May and Stengel (1990) identified several characteristics of the "suers." First, they sought input from numerous sources such as friends and lawyers. The researchers came to this conclusion by asking the participants questions about the "audiences" that they interacted with regarding filing a lawsuit for their medical injury. The audiences included family and friends, informal discussions with a lawyer, and a general knowledge about who to talk to in order to pursue a legal claim. May and Stengel (1990) explained, "The decision to sue requires assertiveness and strategy, and suers appear to engage the involvement and discernment of a broad audience network, while nonsuers show little involvement with the audience network measured here." (116).

May and Stengel (1990) also found that the doctor-patient relationship influenced participants likelihood to sue. They discovered that the patients who questioned their physicians' competence prior to the alleged injury were more likely to sue. They also found that "patients are more likely to sue if their doctors fail to show concern for them personally" (p. 116). The "suers" also reported more serious injuries than the other participants, suggesting that what is at stake influenced participants' decision to sue.

Finally, May and Stengel (1990) explored how "general resources" affected their participants decision to file suit. First, they found that patients who were higher in status than other patients (based on property ownership and education) are less likely to file a medical malpractice suit (p. 118). They also found that "suers" knew less that the other participants about the work of health care or legal professionals. And finally, they found that "suers" were more likely than others to have had prior experience with litigation.

Burstin, Johnson, Lipsitz, and Brennan (1993) found that poor patients are less likely to file suit that affluent patients.[6] The researchers reviewed medical records from New York State hospitals and identified 1,278 adverse events that physician-reviewers deemed to be medical negligence. Notably, some events led to injuries and other did not. The research team then matched 51 malpractice lawsuits and linked them to the adverse events. A sample of 305 patients was taken for the analysis (including the 51 patients that filed suit). Upon further analysis, the researchers found that only 22 of the 51 claimants had suffered an "injury" tied to the adverse event. Burstin et al. (1993) used regression analysis and found that the following "injured" patients were less likely to file suit, even when controlling for injury severity: (1) poor patients, (2) uninsured patients, and (3) elderly patients. For the "non-injured" patients, the researchers again found that poor patients were less likely to file suit than those in higher income brackets.[7]

Another study found that patients filed suit more often when they had poor

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[6] Additional research supports the correlating assertion that affluent patients are more likely to file suit that low-income patients (Hart & Peters, 2008; Miller, Williams, Napolitana, & Schmied, 1990; Doherty & Haven, 1977).

[7] Also see McClellan, White, Jimenez, and Fahmy (2012) for a literature review regarding unconscious bias against poor patients.

relationships with their doctors (Huycke & Huycke, 1994). The researchers worked with six law offices in five states to interview callers to the law firms with medical malpractice complaints. They had 502 calls over 10 randomly selected days in 1991 that were concerning medical malpractice issues. Notably, only one in thirty of the calls eventually led to a formal lawsuit.[8] Huycke and Huycke (1994) found that more than half (53%) of the potential medical malpractice plaintiffs reported that bad rapport with their doctors even before the alleged malpractice occurred. The authors further indicated that prior litigation experience did not necessarily make the patients in their study more or less likely to sue. They found that only 18% of the potential plaintiffs in their study had previously filed suit (excluding divorce). The authors noted that this statistic was in line with national average at the time that 20% of American adults had been involved in some type of litigation (p. 797).

In sum, prior research has identified the following patients as less likely to sue: poor patients, uninsured patients, and elderly patients. On the other hand, patients with prior litigation experience (excluding divorce) and bad rapport with their doctor were more likely to file suit. We now turn to how injured patients seek redress against their doctors.

How do patients file lawsuits?

As Felstiner et al. (1981) pointed out, particular social influences can sway people to file suit or refrain from suing. One such influence that has affected medical

[8] The lawyers did not file suit when the possible damages for the plaintiff were not high enough to cover the litigation costs (this was the situation in 73% of the cases not reviewed by a medical expert and 42% of the cases that were reviewed by a medical expert).

malpractice lawsuits in Texas is the tort reform that was passed in 2003. As discussed above, the Texas legislature capped non-economic damages in health care cases at $250,000 in 2003 (TEX. CIV. PRAC. & REM. CODE ANN § 74.301). Since that time, Texas plaintiff attorneys have been avoiding cases where there are low true economic damages – even when the injury was severe.[9] Daniels and Martin (2007) surveyed sixty Texas lawyers to determine what type of plaintiffs the lawyers favored. The researchers gave lawyers two scenarios where three potential plaintiffs had various types of economic damages that would be unaffected by tort reform and the same non-economic damages tied to a permanently disfigured face. The survey asked if the lawyers would have taken the case before tort reform and if they would take the case after tort reform.[10]

The first scenario was a medical malpractice case (where the non-economic damages would be capped) and the other was an 18-wheeler accident (where no damages would not be capped). The survey presented the participants with three potential plaintiffs with various levels of economic damages: (1) a 70-year-old retired male with minimal economic damages, (2) a 45-year-old married male with a job and dependents, meaning higher economic damages, and (3) a 45-year-old married female that did not work outside the home but had dependents, meaning more economic damages than the 70-year-old retired man, but less than the wage-earning, 45-year-old man.

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[9] Huycke and Huycke (1994) found in their study of incoming calls to six law firms across five unnamed states that lawyers would not take cases where the estimated damages were not enough to cover the litigation costs.

[10] According to Babbie (2010), bias in surveys "refers to any property of questions that encourages respondents to answer in a particular way" (p. 261). One such bias is "social desirability," which encourages respondents to answer in a way that makes them look best (Babbie, p. 261). Daniels and Martin (2007) avoided this problem by making the injury one that the most socially acceptable answer would be to help the injured plaintiff, regardless of tort reform.

For the 18-wheeler accident victims, most lawyers would take the case no matter the plaintiff. Before tort reform, 94.3% of participants would have taken on the 70-year-old retired male as a client, 96.2% would have accepted the 45-year-old employed male as a client, and 98.1% would have represented the 45-year-old housewife. Following tort reform, the numbers decreased slightly to 86.2%, 93.2%, and 90.0%, respectively. The authors did not suggest a reason for the decrease.

The results in the medical malpractice scenario were much different. Prior to tort reform, 61.8% of the lawyers would have represented the 70-year-old retired male, 67.3% would have represented the 45-year-old employed male, and 66.7% would have represented the 45-year-old housewife. Following tort reform and the applicable damages caps, the percentages fell to 13.6%, 37.3%, and 24.6%, respectively. In post-tort reform Texas, plaintiffs' lawyers showed a clear preference for the 45-year-old male hypothetical plaintiff due to his higher earning potential and the highest economic damages. The economic damages would not be capped and would lead to the highest monetary judgment for the plaintiff, and subsequently, the highest contingency fees for the attorneys. Although only sixty lawyers were surveyed, Daniels & Martin's results suggest that many Texas lawyers have stopped taking medical malpractice cases following tort reform in 2003.

If it is more difficult to find a lawyer in Texas after tort reform, injured patients have the option of filing a complaint with the Texas Medical Board (TMB), the

regulating agency for doctors who practice in Texas.[11] Research has shown that more TMB complaints have been filed since tort reform. Stewart et al. (2011) discovered that the number of malpractice lawsuits had dropped in their practice, so they hypothesized that more injured plaintiffs were turning to the TMB to seek redress. Stewart, Love, Rocheleau, and Sirinek (2012) found that following tort reform in Texas, the TMB reported that "complaints against physicians increased 13%; investigations opened increased 33%, disciplinary actions increased 96%, license revocations or surrenders increased 47%, and financial penalties increased 367%" (p. 568).

All of the indicated increases were statistically significant, according to the researchers. However, it is important to note that the most dramatic increase – that to financial penalties – was an increase in the thousands of dollars per 1,000 physicians. The researchers took the total dollar amount of financial penalties assessed by the TMB and determined what that amount would be per 1,000 physicians. The highest penalty value per 1,000 physicians was $4,785 in 2002 (Stewart et al., 2012). After tort reform in 2003, the highest penalty value per 1,000 physicians was $14,853 in 2010 (Stewart et al., 2012). Although these are statistically significant increases, the dollar amount for each physician is not apparent and could be a low percentage of physicians' overall operating expenses. Notably, the researchers did not comment on the reason for these increases; they simply stated the statistics and suggested that aggrieved patients were filing TMB claims in lieu of filing lawsuits. The authors openly admit that this increase in TMB

[11] The Board's stated main objective is to protect the Texas public by establishing and enforcing regulations for physicians (Texas Medical Board, n.d.a).

activity could be coincidental with tort reform, citing patients' increased computer access and reporting capabilities as possible explanations.

Regardless of the reason behind the uptick in TMB complaints and actions, Stewart et al. (2012) have demonstrated that following tort reform, TMB claims and the corresponding penalties for doctors have increased. Although this and related studies are unable to definitively show that aggrieved Texas patients have been forced from the legal system to the administrative system run by the TMB, it is important to note that when a plaintiff pursues a TMB instead of a lawsuit, there is a shift in recovery. Under the legal system, the patient-plaintiff (and his or her lawyer) will receive some sort of payment from the doctor-defendant (and his or her insurance company). But when a patient files a TMB compliant, he or she will not receive payment from the doctor; any monetary penalties assessed against the doctor will be paid to the TMB as a fine. Therefore, this shift in possible recovery paths affects aggrieved patients' potential financial recovery.

How many people file suit?

Baker (2005) also addressed the myth that patients are litigious, suit-happy individuals. He starts his explanation by estimating that depending on how we count, "there are between seven and twenty-five serious medical malpractice injuries for every one medical malpractice lawsuit" (p. 23). Before continuing, it is important to note the wide range in Baker's aggregation of relevant research. As described in his book, the research in the medical malpractice arena has operationalized variables inconsistently. For instance, some research defines "claims" as insurance claims made by individual

doctors or hospitals while other research defines a "claim" as a lawsuit. Other research has looked at medical records to find errors. And even then, errors have been defined in different ways such as not following the established standard of care versus making a mistake that led to an injury of some sort. Therefore, it is difficult to compare studies and make generalized comments regarding injuries that lead to malpractice.

Based on the available data, however, Baker's assertion is well-founded; it is clear that "…there really are very few medical malpractice lawsuits, especially compared to the amount of medical malpractice" (p. 23). Starting with research regarding medical errors in the 1970s, Baker walks through several studies that show there are far more errors in medicine than there are lawsuits filed.

The first major study was commissioned in California by the California Hospital Association and the California Medical Association during the mid-1970s to evaluate the first medical malpractice insurance crisis. Baker explains that it is impossible to know what the researchers were thinking exactly, but he says that they were apparently expecting to find: (1) medical malpractice was not as rampant as lawyers claimed, and (2) that a no-fault system would be better than doctors and hospitals paying insurance premiums.

The researchers made some disturbing discoveries: one out of every 20 patients discharged from hospitals were injured by the "doctors and hospitals" and of those injured, one out of every 10 died. Put a different way, "This meant that doctors and hospitals injured at least 140,000 hospital patients in California in 1974 and killed nearly 14,000 of them" (Baker, 2005, p. 26 citing Mills, 1977, pp. 8, 47, 49, 53). The

researchers went on to determine that one of every six injuries would have been classified as "malpractice" according existing to legal standards. Translated to patients, this means that a doctor or hospital committed malpractice when treating approximately 24,000 California patients. And they also found a direct relationship between injury severity and malpractice, meaning that the more severe the injury, the more likely that it was caused by malpractice. "As many as 80% – four out of every five – of the most seriously injured patients were the victims of medical malpractice" (Baker, p. 26, citing Mills, 1977, p. 100).

Notably, the California study did not include how many injured patients actually filed suit. According to the author, the study's purpose was "to obtain adequate information about patient disabilities resulting from health care management" (Mills, 1978, p. 360). It appears that the study was a fact-finding mission to provide California lawmakers with information regarding the cost of various compensation plans. Therefore, once the health care records were evaluated and legally recognized "medical malpractice" was identified, the study was concluded. There was no mention of the likelihood of the patients filing a lawsuit.

Other studies yielded similar results. The most famous was conducted by researchers at Harvard University and was reviewed in several sources (Baker, 2005; Studdert, Mello, & Brennan, 2004; Haltom & McCann, 2004). The Harvard research team was prompted by the apparent malpractice crisis of the mid-1980s. They reviewed over 30,000 discharge records from hospitals in New York while also evaluating 3,500 malpractice claims in New York. The same team repeated the study in Colorado and

Utah looking for differences in urban versus rural settings. Although the data is reported in a variety of ways, Baker (2005) gave a succinct summary. He explained that in the Harvard study, the researchers reviewed approximately 30,000 New York hospital records and found that 280 patients had suffered a serious injury due to a medical malpractice. Of these 280 injuries only eight patients (less than 3%) actually filed a medical malpractice lawsuit. The same Harvard team reviewed approximately 15,000 Colorado and Utah hospital records and found that medical malpractice had caused 161 serious injuries. Again, only six of the 161 seriously injured patients filed a lawsuit, which again, is less than three percent.[12] Another researcher, Vidmar (2009), restated Baker's (2005) review of the California and Harvard studies by explaining that these studies reveal "that only about one in 25 patients with a negligent or preventable medical claim brought a lawsuit against the health care provider" (pp. 367–368).

The research reviewed in this section indicates that injured patients do not often sue their doctors. It is difficult to file a lawsuit (Felstiner, Abel, & Sarat, 1981) and it has become more difficult in Texas following tort reform (Daniels & Martin, 2007). The research also shows that doctors' risk of being sued in Texas following tort reform has decreased (Stewart et al., 2011). There has also been an increase in TMB complaints after tort reform (Stewart et al., 2012), which will provide no financial benefit to aggrieved patients. And finally, there is long-standing research that most patients do not sue their doctors following a mistake (Baker, 2005). These findings should make Texas

[12] Baker, 2005, p. 69 citing Danzon, 1985, pp. 22-24; Localio et al., 1991, p. 245; and Studdert et al., 2000, p. 253).

physicians less concerned about being sued for medical malpractice. However, it should be noted that for doctors to be influenced by this research, they need to first know about it. And second, they need to be rational decision-makers, which most people are not (Rosalsky, 2015).

In the remainder of this section, I review research about how physicians fare after a medical malpractice lawsuit has been filed. In the first section, I explore the research indicating that the current legal system is operating well and concludes that it actually works to the benefit of physicians. In the second section, I explain how insurance companies are fighting medical malpractice claims.

The Legal System is Working (and in Physicians' Favor)

A second myth concerning medical malpractice is about the state of the legal system – it is plagued with frivolous lawsuits, jury awards are too high, and juries find against doctors based on the perception that doctors are wealthy.[13] But the research shows the legal system is operating efficiently and it seems to favor physicians.

Studdert et al. (2006) found support to debunk the first assertion that there are too many frivolous lawsuits. The Studdert research team found that the legal system is more likely to compensate plaintiffs with valid claims than frivolous ones. The researchers reviewed 1452 closed insurance claims (defined as "a written demand for compensation for medical injury" (p. 2025) from five malpractice insurance carriers. The participating insurers covered approximately 33,000 physicians and were located in four regions of

[13] Dr. B, a participant in this study articulated the second part of this myth, that doctors are perceived as "rich."

the United States – the Northeast, Mid-Atlantic, Southwest, and West. The study evaluated claims from four groups – obstetrics, surgery, missed or delayed diagnosis, and medication.

Studdert's team found that most claims involved an injury. Eighty percent of the claims reviewed involved a significant physical injury (39%), a major physical injury (15%) or death (26%). Most of the remaining claims involved minor physical injury (13%), psychological or emotional injury (4%), or a breach of informed consent (less than 1%). Only in 3% (or 37) of the reviewed claims was there no evidence that the claimant suffered an injury. An example given by the researches involved a claimant that alleged contracting staph infection due to substandard care; however, the medical records revealed no infection.

After determining whether or not a claimant suffered an injury, Studdert et al. (2006) looked for "medical errors" in the 1406 claims that involved an injury. They used the Institute of Medicine's definition of medical errors: "the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)" (p. 2026 citing to Kohn, Corrigan, & Donaldson, 2000). They found that 63% (or 889) of the claims involved a medical error while 37% (or 515) did not. For those 889 claims that had an error, 653 (or 73%) received compensation. For the 515 claims that did not involve an error, 145 (or 28%) received compensation. For those initial 3% of claims that did not involve an injury, only 6 of the 37 (or 16%) received compensation. Thus, the researchers concluded that the current system does a good job in determining which claims have merit and which are frivolous

and compensating the meritorious ones. They summarize, “three quarters of the litigation outcomes were concordant with the merits of the claim” (p. 2031).

Studdert et al. (2006) drew another general conclusion: the myth that the legal system is fraught with frivolous lawsuits is “overblown” (p. 2031). Their review of claims illustrated that it is often difficult for plaintiffs’ lawyers to understand what happened in a situation until a lawsuit is filed and discovery is underway. In discovery, lawyers request and defendants must supply the records which become the “facts” in a given case. Until then, both the lawyers and their clients may not know exactly what occurred.

A more recent article drew similar conclusions. Hyman and Silver (2013) stated that the “liability system does much better than conventional wisdom suggests” deciphering between meritorious and frivolous medical malpractice lawsuits (p. 223). Data from Texas medical malpractice claims from 1998 to 2009 (covering the years before and after the 2003 tort reform) show that most malpractice claims are resolved without payment. The researchers found that from 1998-2003, there were 7,650 medical malpractice claims and 85% closed without any payments being made. After the 2003 tort reform in Texas, in the years 2004-2009, there were 5,300 total medical malpractice claims and 80% closed without payment. Although the percentage of cases resulting in a payout increased, the amount of the payouts decreased from a mean of $609,000 from

1998-2003 to $419,000 from 2004-2009.[14] Hyman and Silver summarized their findings from the 1998-2009 Texas insurance database that only about 2% of claims are tried in court, and if a claim goes to trial, the physicians win approximately 75% of the time (p. 224).

Additional research has been conducted regarding medical malpractice payments. Paik, Black, and Hyman (2013a) studied closed insurance claim information at the national level to gather data regarding medical malpractice payouts.[15] Their data set consisted of claims paid on behalf of doctors (only MDs) that were reflected in the National Practitioner Data Bank for the years 1992-2012 and reflected all information in 2011 dollars. They recognized that various medical malpractice tort reforms had been adopted, so they divided states into three categories: (1) no-cap states (those with no limits or "caps" on non-economic damages for medical malpractice cases); (2) old-cap states (those that adopted non-economic damage caps for medical malpractice cases before 2000) and (3) new-cap states (those that adopted non-economic damages caps for medical malpractice cases in the 2000s). Texas passed tort reform in 2003 and was classified as a "new-cap state."

Paik et al. (2013a) found that the number of medical malpractice payments dropped significantly throughout the study time period from 1992-2012. The research

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[14] The researchers presented payout data for only "large cases," which they defined as "those with payments in excess of $25,000 (1988 dollars) (p. 223). Notably, this amount translated to about $46,000 in 2010 dollars and accounted for 98% of the payouts in the study period.

[15] Information in this study was submitted to the National Practitioner Data Bank by physicians. Therefore, it reflects payments made on behalf of the physician submitting the information. No data was provided regarding how the payments were made (i.e., by the physician, by a hospital, or by an insurance company) or if the amount was paid before or after a lawsuit was filed or if the payment was the result of a jury trial. However, any jury awards should be included in the reported payout amounts.

team found that paid claims per number of "active" physicians dropped 57% nationally during the study.[16] Broken down by tort-reform type, the researchers found the following drops: the 20 no-cap states had a 51% drop; the 19 old-cap states had a 57% drop; and the 12 new-cap sates had a 64% drop. They pointed out that some of the reduction in payments per physician was due to a 72% drop in the number of "small claims," or those less than $50,000, that were paid. The researchers noted, however, that more than 98% of all payments were "large claims," or those greater than or equal to $50,000. There was a 49% drop in large claims nationwide during the study period. To give the reader a full picture, the research team again included the reduction in large claims paid per physician by tort reform-type for the study period: the 20 no-cap states had a 40% drop; the 19 old-cap states had a 49% drop; and the 12 new-cap sates had a 60% drop. [17]

Paik et al. (2013a) also found that the payouts per claim made against medical doctors have stabilized. The researchers point out that the payouts per claim averaged $284,000 in 1992 and rose to $345,000 by 2001, meaning a 21.4% overall increase (p. 621). Again, the researchers attribute this change to the decline in "small claims." When the researchers excluded smaller claims and only looked at larger claims, the average payout was $416,000 in 1992 and was $426,000 in 2011, with a modest fluctuation from $399,000 to $440,000 in the intervening years.

A great deal of information can be gleaned from Hyman and Silver (2013) and Paik et al. (2013a) that should comfort Texas physicians. First, from Hyman and Silver,

[16] The researchers compared claims to the number of "active" physicians in each state; they defined "active" physicians as all "active, nonfederal, patient-care physicians by state and year" (p. 616).
[17] See Paik, Black, and Hyman (2013b) for a more detailed analysis regarding how damages caps affected medical malpractice claim payouts.

we know that there are less medical malpractice claims filed in Texas after tort reform. Second, the average payout amount for large cases in Texas dropped $190,000 after tort reform. And finally, we learned that of the 2% of claims that go to trial, physicians prevail in an estimated 75% of the cases. Paik et al. (2013a) then documented that there has been a significant decrease in the number of payments that were made per physicians from 1992-2012. For Texas, a new-cap state, there was a 60% drop in the number of payments made. When payments are made, the amount has hovered at just over $400,000.

A final point about how physicians fare in the current legal system is that when a medical malpractice case goes to a jury, the jury often sides with defendant doctor. Vidmar (2009) researched medical malpractice cases in 75 of the largest U.S. counties. Based on his research findings, he estimates that a mere 7% of medical malpractice lawsuits are decided by a jury, suggesting that the remaining cases are either dismissed or settled before trial or heard by a judge in a bench trial. In a correlating statistic to Hyman and Silver's (2013) findings above, Vidmar (2009) found that plaintiffs only win 27% of medical malpractice cases. He also points out that juries often reach the same conclusions as medical experts regarding doctors' negligence (citing Taragin, Willet, Wilzek, Trout, & Carson, 1992).

Based on the research cited in this section, it appears that the legal system is weeding out frivolous lawsuits, that payments to medical malpractice plaintiffs has remained relatively flat, and that juries side with doctors in most cases. These facts should help dispel the fears doctors have regarding how they fare in the formal legal

system. We now turn to a third concern – that insurance companies do not fight medical malpractice claims.

Insurance Companies Fight Medical Malpractice Claims

Baker (2005) also addressed the myth that insurance companies do not fight medical malpractice claims and routinely pay to settle cases that a doctor could have won. Both Baker and Haltom and McCann (2004) cite to a study of a New Jersey insurance company to make their point (Taragin et al., 1992).

Taragin and his colleagues reviewed over eight thousand claims from a large New Jersey medical malpractice insurer. The researchers first looked at how the insurance company's experts classified each claim with regard to the doctors' actions; the actions were deemed to be – "defensible," "indefensible," or "unclear" (pp. 780–781). In about one-quarter of the cases, the physicians' actions were found to be "indefensible," and the insurance company paid some amount in 91% of those cases. On the other hand, the insurance company found 62% of claims to be "defensible." The insurance company only made payments in 21% of the "defensible" claims.

As for the amounts paid, at least some payment amount was paid in 43% of all cases. Of the paid cases, the payment amount was less than $50,000 for 52% of them. A payment amount exceeding $200,000 was made in only 15% of the paid cases. The median payment across all cases was $45,551 and ranged from $24 to $3,965,000. The researchers found that higher payment amounts correlated to more severe injuries, citing that "the median payments for injuries of low, medium, and high severity were $7,189, $50,000, and $115,089, respectively" (p. 781). Baker (2005) summarized this study

with, “the insurer only very rarely paid weak claims” (p. 79).

Perhaps some of the best data regarding medical malpractice comes from the insurance companies. Fortunately, the Texas Department of Insurance requires insurance companies to report information on closed medical malpractice claims, regardless of whether a payment was made. Black, Silver, Hyman, and Sage (2005) conducted research and reported their findings in, “Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas 1988-2002.” The Black et al. team did find information that could alarm any Texas doctor: from 2000-2002, doctors in Texas had a 25% chance of being involved in a claim (p. 235). However, the researchers found that 80% of claims were closed without payment. In fact, the researchers determined that from 1990 to 2002, the number of claims less than $25,000, or “smaller paid claims,” fell severely. Large claims (those at least $25,000 in 1988 dollars) and the total number of paid claims also showed a decline for the same time frame when the researchers adjusted for the “number of physicians or growth in real health-care spending” (p. 209).

The same Texas Insurance Database was used by Silver, Zeiler, Black, Hyman, and Sage (2008). Their research yielded two interesting findings. First, like most insurance policies, payments made to claimants for medical malpractice claims rarely exceeded the policy limits. The researchers actually found that insurers (primary and excess) paid “over 99% of the dollars paid to claimants” (p. 188). They suggested that the policy amount acted as a sort of “cap” for the case.

The second finding was that physicians rarely made the payments out of their own pockets (p. 188). Physicians made out-of-pocket payments in only 62 of the 8,400

cases included in the study. In 18 of those cases, the insurance company did not pay the full policy amount. Possible explanations offered by the researchers included defendant's refusal to settle or a plaintiff's insistence that the doctor individually pay. The researchers found that the amount of insurance a physician carried affected whether or not they personally paid. Physicians that carried less than $250,000 in insurance made a payment in 32 cases of 2,488, which was 1.3% of the cases. Physicians who carried $500,000 or more in insurance paid out personally in 23 of 6,160 cases, or 0.4%. Therefore, carrying additional insurance should guard physician against personally paying an adverse judgment.

The facts detailed in this section should help allay doctors' fears regarding medical malpractice. The research has shown that injured patients do not always sue. In fact, following tort reform in Texas, it has become more difficult to find a lawyer willing to file a lawsuit. The research also shows that if a doctor is sued, the current legal system is operating as intended in that medical malpractice plaintiffs with legitimate claims are awarded damages and those with frivolous claims are not. And finally, medical malpractice insurers are actively fighting medical malpractice claims on behalf on their insured physicians. The following section examines the research to date regarding physicians' medical malpractice concerns.

Medical Malpractice – The Doctors' Mindset

Despite the facts detailed above, existing literature suggests that doctors are more concerned about medical malpractice lawsuits than they should be. The most on-point (and often-cited) study was conducted by Lawthers et al. (1992). Their stated rationale

for their study was to examine the overarching goal of American malpractice structure – to deter undesirable (or here, negligent) behavior (pp. 463–464). As such, they sought to determine if there was a "deterrent signal" received by physicians, and if so, what behaviors did they employ as a result. The research team pulled samples from the American Medical Association ("AMA") survey data collected from 52,764 practicing physicians in New York State in 1984. They used secondary data from the New York State Department of Health and the AMA to determine doctors' actual risk of being sued.

Lawthers et al. (1992) found that the physicians surveyed believed that "60 percent of negligent adverse events lead to suits" (p. 475). The authors admit that the 60% figure is far from a belief that they will "always" be sued following a negative outcome, but "it is *thirty times* higher than the actual risk of being sued for negligence" (p. 475, emphasis original). In fact, the authors found that less than 2% of New York State patients injured due to negligence actually filed malpractice lawsuits.[18] Lawthers et al. (1992) also point out the negative side of the deterrent effect – many physicians worried that they would be sued for bad patient outcomes even when there was no negligence involved. The study indicated that 45% of physicians perceived a "substantial chance of being sued for non-negligent adverse events" (p. 475). Lawthers et al. (1992) suggested that tort reforms could reduce physicians' perceived risk of malpractice suits detailed in their study.

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[18] The researchers used the definition of negligence set out in the Medical Practice Study protocol, see Localio et al., 1991.

However, the suggestion that tort reform, such as the Texas tort reforms discussed in the introduction, would mitigate physician fears was disproved by Carrier et al. (2010). The researchers reviewed data from the 2008 Center for Studying Health System Change (HSC) Health Tracking Physician Survey. The mail survey was completed by 4,720 physicians from all specialties. The researchers also used secondary data to determine state-level malpractice risk and related malpractice insurance premiums for the respondents.

Carrier et al. (2010) focused on the responses from the malpractice concerns scale that had been created and validated by Kevin Fiscella and collaborators (see Fiscella et al., 2000; Katz et al., 2005; Franks, Williams, Zwanzinger, Mooney, & Sorbero, 2000; Reed et al., 2008). The five statements included were:

> (1) I am concerned that I will be involved in a malpractice case sometime in the next ten years. (2) I feel pressured in my day-to-day practice by the threat of malpractice litigation. (3) I order some tests or consultations simply to avoid the appearance of malpractice. (4) Sometimes I ask for consultant opinions primarily to reduce my risk of getting sued. (5) Relying on clinical judgment rather than on technology to make a diagnosis is becoming risky because of the threat of malpractice suits. (p. 1586)

The first, second, and fifth statements represent "malpractice concerns," while the third and fourth represent "defensive medicine" actions. Participants expressed their level of agreement with each statement was answered with a 5-point Likert scale ranging from "strongly disagree" to "strongly agree."

Carrier et al. (2010) found that doctors were worried about malpractice liability. In fact, 60-78% of the responding physicians "agreed" or "strongly agreed" with all five of the statements. What is more interesting, the researchers found that, "Overall, physicians' malpractice concerns appear to be relatively insensitive to their states' malpractice reforms, including caps on noneconomic and punitive damages" (p. 1588–1589).

Another study of medical malpractice and physicians' perspectives looked specifically at radiologists. Elmore et al. (2005) surveyed radiologists who were interpreting mammograms. The physicians surveyed were those who reported results to mammography registries in three states – Washington, Colorado, and New Hampshire. The study focused on 124 responding radiologists who had interpreted more than 480 mammograms.

The survey asked radiologists about their medical malpractice experience and concerns. Questions offered five answer choices using a 5-point Likert scale. The study found that about half (52.5%) of respondents reported a prior malpractice claim, with 14.8% reporting a claim related to a mammography (Elmore et al., 2005, p. 39). For those sued, 81.0% reported the experience to be "very or extremely stressful" (p. 39).[19]

The radiologists reported malpractice concerns and reactions to those concerns. More than three-fourths of radiologists – 76.4% – answered that they "agreed or strongly agreed that they are concerned about the impact medical malpractice is having on their

[19] Although this percentage seems high, there is a lack of research regarding how physicians are emotionally affected by lawsuits. Recent studies that show that doctors are negatively affected following "medical errors" (Elwahab & Doherty, 2014; O'Beirne, Sterling, Palacios-Derflingher, Hohman, & Zwicker, 2012; Waterman et al., 2007).

practice of mammography" (Elmore et al., 2005, pp. 39–40). Almost one third of the radiologists (27%) reported that they consider, at least monthly, discontinuing mammography from their practice due malpractice concerns. Most radiologists – 72.4% – reported that concerns about medical malpractice caused them to act defensively by ordering more diagnostic mammography and/or ultrasounds (Elmore et al., 2005, p. 40). In fact, more than half of the radiologists surveyed (58.5%) believed that their concerns regarding malpractice increased the number of breast biopsies the physician recommended.

However, the researchers found that there was no direct link between the radiologists' malpractice concerns and their "recall rates." Recall rate was defined as "the number of mammograms interpreted as positive [for cancer] divided by the total number of mammograms" (Elmore et al., 2005, p. 39). The research team hypothesized two possible explanations for the lack of a relationship: (1) there is simply no relationship and physicians have overestimated the effect or (2) malpractice concerns are so widespread that all physicians, even those who claimed not to be concerned and who had never been sued, are unconsciously practicing defensively. Elmore et al. (2005) posited that the second explanation is correct because Elmore and other collaborators had previously found an increasing recall rate among radiologist in a study conducted from 1983-1995 (Elmore et al., 1998). The researchers explained that this increased recall rate from the previous study occurred "as malpractice concerns have risen" in the United States (Elmore et al., 2005, p. 44). Therefore, they surmised that the radiologists are practicing defensively.

Before concluding this section, I want to highlight another study regarding medical students and their medical malpractice concerns. As I indicated in the introduction, I had anecdotally learned from my teaching experience that medical students were worried about medical malpractice; Kelly and Miller (2009) studied attitudes in this population. They surveyed 109 first- and fourth-year medical students at Brown University. The researchers asked a series of questions including: "What is your perception of the validity of most medical malpractice lawsuits?" and "How concerned are you about medical malpractice in your future practice of medicine?" (p. 74). Each question had a 5-point Likert response.

Kelly and Miller (2009) found that, "Regardless of year in medical school, however, medical students' perceptions of medical malpractice were overwhelmingly negative" (p. 76). When answering the question – "How concerned are you about medical malpractice in your future practice of medicine?" – 50% of the students responded, "A serious consideration" or "Tremendously" (Kelly & Miller, 2009, p. 74). Perhaps their concern stemmed from the number of baseless lawsuits they estimated were brought against physicians. More than half of the participants, 55.6%, answered that of every 10 medical malpractice lawsuits, five or more have no physician negligence (Kelly & Miller, 2009, p. 73).[20]

The study did find one item that changed over time – the fourth-year medical students were more interested in tort reform measures. The researchers pointed out that

[20] As explained above, many medical malpractice lawsuits did involve a "medical error," which in the legal system would be considered "negligence." Studdert et al. (2006) reviewed insurance claims from various U.S. markets and found that 63% (or 889) of the claims involved a medical error while 37% (or 515) did not.

the same reforms were favored by the AMA, suggesting that the AMA had influenced the students during their medical school careers. Students identified the following sources that informed their perspective: the media, practicing physicians, classroom discussions, and interactions with other students outside of class. Such informal sources of information could influence not only the students in this study, but also practicing physicians as well.

The existing research illustrates that physicians are more concerned about medical malpractice lawsuits than the empirical data would merit. Lawthers et al. (1992) showed that doctors believed that 60% of negative medical events would lead to suit, however, the data indicate that only about 2% of injured patients actually file suit. Carrier et al. (2010) showed that physicians are worried about medical malpractice cases, even physicians that practice in states like Texas that have caps on noneconomic damages in medical malpractice cases. Elmore et al. (2005) found that radiologists are concerned about medical malpractice; 76.4% said that their concern over medical malpractice impacts their practice in mammography cases and 81% of those that were sued considered the experience to be stressful. And finally, Kelly and Miller (2009) found that the medical malpractice concerns expressed by doctors extended to medical students as well. More than half of the students in Kelly and Miller's study were concerned about medical malpractice lawsuits. The information in these studies gives some insight into doctors' level of medical malpractice concern. In the next section, I review the existing explanations and the related data for doctors' concerns.

Why the Doctors' Mindset Exists and Persists – Possible Explanations

When answering why doctors buy into the "medical malpractice" myths and why their beliefs are misaligned with the research, Baker (2005) explained, "I do not have a better answer to these questions than their self-interest and the influence of organized medicine" (p. 40). He posited that most doctors are working more than sixty hours per week and simply do not have the time to focus on, much less conduct an in-depth review of, medical policy literature. He surmised that doctors gather information from talking to one another each other and when they process the information, they interpret it in a self-interested way. Baker further asserted that "organized medicine," such as the AMA and other organizations intended to represent the doctors' interests, disseminates "…horror stories about medical malpractice litigation and insurance, to the point where ordinary doctors can almost be forgiven for still believing that medical malpractice litigation is a more serious problem than medical malpractice" (p. 40).

Baker's two proposed answers to why doctors' beliefs regarding medical malpractice persist operate at two levels. First, the self-interest explanation operates on the micro, or individual physician level. The second explanation, that organized medicine has worked to perpetuate doctors' medical malpractice beliefs, functions at macro, or organizational, level.

Majoribanks, Delvecchio Good, Lawthers, and Peterson (1996) conducted a study of doctors' medical malpractice beliers that operated at the same two levels proposed by Baker (2005). Majoribanks et al. (1996) identified medical malpractice "discourses" from two sources – interviews from physicians (micro level) and brochures

from the AMA to physicians (macro level – discussed below). The researchers reviewed interviews from the 1988 and 1989 Harvard Medical Practice Study. The interviewers were physicians or medical anthropologists; they used an open-ended interview guide to interview 47 physicians in 1988 and 1989. The physicians were from three fields – general surgery, obstetrics, and internal medicine. The AMA materials examined were found in the 1992 "Medical Liability Project's publicity folder," which was published by the AMA/Specialty Society.

The remainder of this section reviews possible explanations as to why physicians' medical malpractice beliefs persist, first at the individual (micro) level and then at the organization (macro) level.

Understanding – The Individual Doctor's Perspective

To explain why doctors fear medical malpractice, Baker cited a concept from psychology called the "self-serving bias." The self-serving bias is "the tendency for parties to arrive at judgments that reflect a self-serving bias – to conflate what is fair with what benefits oneself" (Babcock & Lowenstein, 1997, p. 110). Baker posited this is what doctors are doing when they process information about medical errors as compared to medical malpractice lawsuits. He pointed out, as do Babcock and Lowenstein (1997), that this self-serving bias is "nearly universal" in its applicability and is not attributable to doctors alone (Baker, 2005, p. 41). Baker went on to say this bias "means that stories about unfair lawsuits literally count more than the occasional references to research on medical mistakes, despite the fact that the research is a far better guide to medical malpractice and medical malpractice lawsuits" (p. 41).

The Carrier et al. (2010) research team also offered a physiological explanation for doctors' malpractice fears. They posited that the fear is related to rare but catastrophic events. They suggest that, "Severe, unpredictable, uncontrollable events are associated with a feeling of dread that triggers a statistically irrational level of risk aversion" (p. 1591, citing Slovic, 1987).

The Majoribanks et al. (1996) study introduced above identified four themes that showed individual doctors and the AMA were resistant to the legal system.[21] "(1) affective lament; (2) rejection of tort law; (3) complaints about a deterioration in the culture of clinical practice; and (4) a call for active campaigning" (p. 163). The first three themes were attributed to individual physician responses and are reviewed below.

Fist, the affective lament theme was identified by the researchers based on physicians' comments regarding how upset they were during the legal process, including feelings of humiliation. Physicians said that they were overwhelmed by a medical malpractice lawsuit. The researchers included illustrative comments such as "[being sued] was mind-shattering, ego-shattering…" and "You see yourself as a villain" (pp. 167–168).

For the second theme, tort law rejection, the researchers explained that doctors' saw the courtroom as a foreign territory and that they should not have to explain their medical choices to people who are not medically trained. The researchers stated that doctors have a "belief that what goes on in the courtroom has little to do with the reality

[21] Here, the four discourses are reviewed from the individual doctor's perspective (micro-level). The discourses are reviewed again in the following section with respect to the AMA (macro-level).

of competent medical practice" (Majoribanks et al., 1996, p. 169). Comments such as, "You'll be on foreign territory being attacked by a guy in his own profession on his own set of rules" illustrated how doctors viewed the legal system as foreign (Majoribanks et al., 1996, p. 170).

Also within the tort law rejection theme was an assertion by the physicians that medical malpractice lawyers were playing a "game." (p. 170). One such comment included by Majoribanks et al. (1996) demonstrated participants' sentiments, "It becomes a game in court. It is a show to try and convince a jury or a collection of people that your view is more right than the other person's view" (p. 170). The Majoribanks et al. (1996) participants clearly saw the legal system as "foreign" and identified it as an unfair "game."

The third resistance theme, the negative effect on clinical practice's culture, was derived from doctors' comments about how malpractice concerns had influenced their interactions with patients and the tests they order for patients. Several mentioned becoming "more careful" (p. 173) in their work. Such actions have since been described as practicing defensive medicine, which is still being studied today.

Another point Majoribanks et al. (1996) identified within their "negative effect on clinical practice" theme was physicians' concern over the loss of professional control when a malpractice claim is filed. The researchers found, "Central to the experience of physicians in their interaction with the law is a challenge to the dominance that they exercise in their practice on a daily basis" (p. 169).

Baker (2005) makes this same point regarding physicians' loss of control. Early

in his book, he points out that doctors have a different working world than other professionals. Many doctors are in control of their days and patients wait for them (sometimes for hours). Doctors are not accustomed to following someone else's schedule much less another person's orders. Baker (2005) says, "Lawsuits interrupt that orderly flow of purposeful activity and deprive doctors of that sense of control" (p. 18).

Baker (2005) also explains that the elements in a medical malpractice case can contribute to doctors' fears. This explanation is akin to Majoribanks et al.'s (1996) second theme regarding doctors' rejection of tort law as "foreign territory." To prove medical malpractice in Texas, a plaintiff must show (1) the lawsuit centers on a health care claim against a doctor or a health care provider, (2) the defendant had a duty of care to the plaintiff, (3) the defendant breached that duty by not conforming to the required standard of care, and (4) the defendant's breach proximately caused the plaintiff's injury (O'Connor, 2005, p. 409).[22] Baker (2005) explains that it is the standard of care that is problematic because doctors are held to the standard of a "reasonable doctor" (p. 16). As Baker (2005) correctly points out, most jurors are not doctors so experts must be brought in to establish the standard of care. Therefore, doctor-defendants must hope that their expert(s) can adequately explain the standard to the jurors and that their expert does a better job than the patient-plaintiff's expert. The plaintiffs also bring experts to trial and most cases turn into a "battle of the experts," where doctors for both sides explain the

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[22] Notably, following tort reform in Texas, a different standard was set for emergency room physicians. Plaintiffs must prove that the physician's negligence was "willful and wanton" (TEX. CIV. PRAC. & REM. CODE ANN. § 74.151). At least one Texas court has equated "willful and wanton" with "gross negligence," which is a difficult standard for plaintiffs to prove (see *Turner v. Franklin*, 325 S.W.3d 771 (Tex. App. — Dallas 2011, pet. denied)).

facts and what a "reasonable doctor" would have done given the facts of any particular case. These battles have become so intense that even doctors are calling for "rules of engagement" for the process (Satiani, 2006).

To summarize, researchers have suggested that doctors focus more on the negative stories regarding medical malpractice lawsuits than on the research regarding medical malpractice. Majoribanks et al. (1996) went on to reveal how doctors perceived medical malpractice and detailed three overarching themes: a feeling of sadness over being sued, a distaste for the legal system, and a sense that malpractice erodes their medical practice. The final theme was restated as a loss of control, which was also articulated by Baker (2005). And finally, Baker (2005) pointed out that the complexity of the legal system also contributes to doctors' medical malpractice stress. In the next section, the AMA's possible role in contributing to doctors' perceptions is reviewed.

Understanding – The Impact of Organizational Rhetoric

Baker's (2005) second suggestion mentioned above – that organized medicine influences doctors – is also persuasive. He suggested that the AMA and other organizations that represent doctors could educate their membership about the research that combats the medical malpractice myth, but he explains, "the results would not serve the short-term financial and political interests of their members" (p. 41).[23]

Carrier et al. (2010) also offered a possible macro-level explanation for the gap between doctors' concern about medical malpractice liability versus the actual risk. They

[23] Baker cites to theologian Reinhold Niebuhr's (1960) *Moral Man and Immoral Society* to explain medical organizations' political behavior.

suggested that physicians might "lack access" to information regarding the real risk of being sued (p. 1591). They point to efforts by "medical professional societies" (which I read as "the AMA") that support tort reform. Although not overtly stated, the authors seem to suggest that the AMA is publishing only pro-tort reform materials.[24]

The Majoribanks et al. (1996) research team suggested that the AMA is actually speaking on behalf of doctors. They labeled the AMA's involvement in the public discussion regarding medical malpractice as "an important organized voice representing the profession" (p. 166). By reviewing "Fact Sheet" brochures disseminated by the AMA/Specialty Society in 1992, the researchers identified several discourses promoted by the AMA. First, the researchers explain that the AMA sought to raise physicians' political awareness. The AMA offered physicians specific guidance in responding to the "Malpractice Crisis" in public settings:

> *Did you know that right here in* [Insert the name of your city or county] *a doctor who delivers babies has to pay* [Insert your state's obstetrical insurance premium] *a year in insurance premiums? That's money that has to be paid before the doctor can open the office each year. It's a cost that will have to be passed on to each and every patient.* (Majoribanks et al., 1996, p. 168, citing AMA/Specialty Society Fact Sheet 1992, emphasis original)

The researchers viewed these scripts from the AMA as tools for doctors to combat their feelings of "Affective Lament." Because the researchers were working with secondary

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[24] I only found pro-tort reform information from the AMA in my research. According to the AMA's website, the organization is working to enact tort reform at both the state and federal levels (American Medical Association, n.d.).

data, they did not have the opportunity to ask the doctors if they used these scripts and/or if they were useful.

The Majoribanks et al. (1996) researchers found that the AMA materials echoed the themes identified in the physician interviews. The AMA criticized the legal system as a "foreign territory" and suggested that malpractice claims were simply a "game" (p. 170). The researchers interpreted this criticism as the AMA's effort to "reassert medicine's control and redefine the medical liability game in the profession's favor" (p. 171). Like the physicians, the researchers explained that the AMA echoed physicians' sentiments that medical malpractice claims negatively influence the doctor-patient relationship and erode the physicians' latitude in making treatment decisions. And finally, the researchers found that the AMA materials called for moving medical claims out of the court system and into an administrative agency run by physicians (p. 175).

Although Majoribanks et al. (1996) reviewed themes from the AMA, they did not evaluate how the AMA or other organizations could be influencing physicians. In addition, no research I have found to date critically evaluates organizational rhetoric. In fact, one researcher expressly states that, "This Essay does not take issue with the claim[s] of the American Medical Association and other parties urging 'tort reform'…" (Vidmar, 2005, p. 1218).

Therefore, an opportunity exists to ask doctors if they are influenced by organizational information regarding medical malpractice. As detailed below, the participants were asked to reveal any such influences. Before moving to the methodology in Chapter 2, the final section in this chapter reviews the research

questions for this study.

Why the Doctors' Mindset Exists and Persists – Theories to Explore & Research Questions

To understand why doctors' beliefs regarding medical malpractice are not aligned with the research regarding medical malpractice, we must understand their perspective and how that perspective was formed. I plan to employ two theories – legal consciousness and sensemaking – to obtain that understanding.

Sociologists have used the concept legal consciousness to capture the discursive nature of how individuals understand the law (e.g. Trubek, 1984; Merry, 1990; Marshall, 2005; Baumle, 2009). It has been most broadly defined as "all the ideas about the nature, function, and operation of law held by anyone in society at a given time" (Trubek, 1984, p. 592). More simply, legal consciousness is "the ways people understand and use law" (Merry, 1990, p. 5).

According to Silbey (2005), legal consciousness developed during the 1980s and 1990s to "address issues of legal hegemony, particularly how the law sustains its institutional power despite a persistent gap between the law on the books and the law in action" (p. 323). Ewick and Silbey (1998) described legal consciousness as individuals' participating in the process of creating "legality" (p. 45). They explained, "Every time a person interprets some event in terms of legal concepts or terminology – whether to applaud or to criticize, whether to appropriate or to resist – legality is produced" (p. 45).

In order to help explain the constitutive nature of legal consciousness, Ewick and Silbey (1998) identified three types or forms of participation – individuals were either

"before the law," "with the law," or "against the law." Notably, these categories are not mutually exclusive; in fact, a person could exhibit all three types of legal consciousness in reference to one event (p. 50). Ewick and Silbey (1998) developed these three categories following their conversations with 430 interviews conducted in the early 1990s.

In the first legal consciousness category – "before the law" – participants referred to the law as a separate, authoritative entity. The law was something larger than the individuals, and it was viewed as objective and far away. According the Ewick and Silbey (1998), "the law is described as a formally ordered, rational, and hierarchical system of known rules and procedures" (p. 47). Participants expressed a reverence for the law even though they became angry that they were defenseless or powerless when before the law.

In the other two forms, people were less deferential to the legal process. When acting "with the law," participants described the law as a game that they were playing in order to accomplish their desired goals. They accepted legal rules but did not necessarily agree with them. These participants were more concerned with their ability to navigate the legal system than with the law's power over them.

Finally, Ewick and Silbey (1998) detailed the "against the law" category. In this form of participation, participants felt trapped by or opposed to the law. Ewick and Silbey (1998) found that their participants worked to resist the law and any associated costs, even if the resistance was temporary in nature. Interestingly, the researchers found

that participants acted with a sense of "justice and right" in lieu or a more cynical view (p. 49).

Ewick and Silbey's (1998) framework has been criticized as resulting in "too much and too little law" in existing legal consciousness research (Marshall, 2005, p. 13). For the "too much law" argument, Marshall (2005) explained that critics have claimed that legal consciousness research that studies social interactions with the law has privileged law over other possible influences, such as "structural bases of inequality, particularly race, class and gender" (p. 13). Levine and Mellema (2001) directly criticized Ewick and Silbey for "prioritiz[ing] law above other forces and institutions in interpreting legal consciousness" (p. 171).

In response to these criticisms, legal consciousness scholars have focused on specific, non-legal contexts in which to study legal consciousness. This work includes Marshall's (2005) study of sexual harassment in higher education, Hull's (2006) research regarding same sex marriage, and Nielsen's (2000) work regarding offensive public speech. Nielsen (2000) described legal consciousness as a shift from viewing law as separate from individuals to a "constitutive perspective" (p. 1058). She defines legal consciousness as "not only explor[ing] how people think about the law (consciousness about the law) but also the ways in which largely unconscious ideas about the law can affect decisions they make" (p. 1058).

At the other end of the spectrum, critics claimed that the concept of legal consciousness has "too little" to do with the law. Mezey (2001) pointed out that Ewick and Silbey's reliance on Foucault's theory of power recasts what "the law" means.

Mezey (2001) argues, “By looking for the exercise of power in the mundane extremities of everyday life, by locating legality wherever vaguely legal concepts are embedded in social practices, Ewick and Silbey radically reconceptualize what the law is” (p. 153). Pulling back from this criticism, Mezey goes on to compliment Ewick and Silbey’s framework for “facilitate[ing] the work of legal and sociolegal scholars who want to investigate the relationship between legal and cultural production in the context of particularized legal questions” (p. 154).

Even Silbey (2005) has expressed a need to move legal consciousness research further by exploring “the middle level between citizen and the transcendent rule of law: the ground of institutional practices” (p. 360). In her review, Silbey (2005) criticized the concept of legal consciousness: “Rather than explaining how the different experiences of law become synthesized into a set of circulating schemas and habits, the literature tracks what particular individuals think and do” (p. 323). In the same vein, Marshall (2005) suggested “legal consciousness should be situated in a particular institutional and organizational context” (p. 170). To that end, I would like to explore how physicians’ understand the legal concept of medical malpractice.

The general concept of legal consciousness, and specifically Ewick and Silbey’s (1998) three forms of participation – before, with, or against – the law, can be used to explore how physicians make sense out of their thoughts about medical malpractice. In fact, these participatory forms were present in the themes identified by Majoribanks et al.’s (1996), such as acting “with the law” by treating it as a game and being “against the law” by feeling a loss of control when being sued.

In order to avoid the criticisms levied against prior legal consciousness research, this study focuses specifically on one context – physicians practicing in Texas – and one particular legal issue – medical malpractice. Therefore, the overarching research question is:

> RQ 1: How do physicians make sense of medical malpractice in Texas and what strategies do they employ to cope with risk?

A second, related research question is also explored in this study. When it comes to legal consciousness, Marshall and Barclay (2003) pointed out, "Legal rules only shape behavior when people know them and expect them to be enforced" (p. 622). How physicians learned these rules and the sources they cite are important. For instance, where did physicians get their information regarding medical malpractice? Is it from personal experiences or from external sources (such as the AMA) or some combination of both? Do organizations play any role in shaping physicians' medical malpractice understanding? Therefore, the following research question was also asked:

> RQ2: What are the sources that physicians' cite for how their medical malpractice understanding developed?

This study seeks to deepen the analysis in answering these questions by using Ewick and Silbey's (1998) framework of "before the law," "with the law," and "against

the law," and overlaying the communication theory of sensemaking to further explicate doctor's legal consciousness within these categories. While legal consciousness can explain how doctors interpret the law, Weick's (1995) sensemaking goes a step further than simple interpretation. Sensemaking is the *process* by which an individual comes to understand the law.

Said another way, sensemaking adds another level of nuance to legal consciousness. Weick (1995) made clear that sensemaking is more than mere cognitive interpretation; it is an active, ongoing process. He explained, "Sensemaking is clearly about an activity or a process, whereas interpretation can be a process but is just as likely to describe a product" (Weick, 1995, p. 13). Weick (1995) illustrated the difference between interpretation and sensemaking with an example from a research study that identified cues that employees interpreted. He explained a sensemaking approach would look also at how the cues developed and why specific cues were chosen as important while others were ignored. Weick (1995) said,

> The process of sensemaking is intended to include the construction and bracketing of the textlike cues that are interpreted, as well as the revision of those interpretations based on action and its consequences. Sensemaking is about authoring as well as interpretation, creation as well as discovery. (p. 8)

To explicate this concept, Weick (1995) offered an example of jurors determining a verdict and then conducting the deliberations in a way that leads to their pre-determined verdict (citing Garfinkel, 1967). When this occurred, the jurors were deciding in the course of deliberations which evidence should be highlighted and they

choose facts that supported their verdict. Weick pointed out that the jurors selected the facts "retrospectively" and actively made sense of the information they had been presented at trial. This iterative, active process is sensemaking (p. 13).

Characteristics of Sensemaking

Sensemaking has the following seven characteristics: grounded in social identity, retrospective, enactive of sensible environments, social, ongoing, focused on and by extracted cues, and driven by plausibility rather than accuracy. Each characteristic is detailed below.

Sensemaking: Identity

As Weick (1995) explains, "Sensemaking begins with the sensemaker" (p. 18). And as sensemakers, we are continuously defining, testing, and negotiating our identities in social settings. As we interact with others, the other actors and our environments are responding and shaping our identities. Identities are malleable and reformed based on their environment. According to Weick (1995), "…self, rather than the environment, may be the text in need of interpretation. How can I know who I am until I see what they do?" (p. 23). For instance, one of my participants talked about being a new doctor and not feeling like a doctor. She said, "you're just scared to do anything. Scared to prescribe Tylenol. Tylenol, right!?!" As patients and other doctors started treating her as a doctor, she became more confident. She started to identify herself as a doctor. These interactions with and reactions from others shaped her identity.

People can have multiple identities through which they make sense. And different identities can take precedence over others depending on the circumstances. For

instance, one participant talked about her identity as a doctor, as a mother, as a wife, and as a daughter. She highlighted different identities when speaking about different topics, indicating that certain aspects of her identity were moved to the forefront while others were less important when discussing a topic.

Sensemaking: Retrospective

Sensemaking is a retrospective activity. In order to engage in the sensemaking process, actors review experiences that have already occurred. Weick (1995) points out that many of us think of experiences as "distinct, separate episodes" (p. 25). Weick argues that our lived past is actually an ongoing flow of events. He goes on to say that we make the past into distinct events, "but the only way we get this impression is by stepping outside the stream of experience and directing attention to it" (p. 25). By reviewing what has already happened, even temporally close in time to the present, we are able to categorize, classify, and make meaning of events.

Weick (1995) stresses that our current situation will influence the meaning we make when we look back at our past and anticipate what the future holds for us. Therefore, the meaning we make of a situation today could be different than the meaning we make of it tomorrow; our sensemaking processes are ever-evolving and ever-changing based on the moment we choose to make sense of a situation and the thoughts we possess, in that moment, regarding the future.

Sensemaking: Enactive

Weick (1995) explains that sensemaking is an "enactive process." He chose this word strategically as it indicates what legislators do when they "enact" laws. They are

communicating the rules that must be followed. At the same time, they are creating the environment in which they (and all others in their jurisdiction) will live in. Weick (1995) stresses the fact that the sensemaking process is similarly constitutive. As people make sense of situations, they are at the same time constructing the reality in which they live. Weick (1995) says, "There is *not* some monolithic, singular, fixed environment that exists detached from and external to these people…they act, and in doing so create the materials that become the constraints and opportunities they fact" (p. 31, emphasis original). Therefore, when actors engage in sensemaking, they are not only creating meaning for themselves, they are also making meanings for the other actors who make up their environments.

Sensemaking: Social

Sensemaking is not an individual activity; sensemaking involves making meaning through social interactions. It is by projecting ourselves in our environments that we are reflected back who and what we are as well as the perceptions of others. Weick (1995) explains, "Conduct is contingent on the conduct of others, whether those others are imagined or physically present" (p. 39). He also points out that the social nature of sensemaking goes beyond just a "shared meaning" or "social construction" (p. 41). He says that it can also include distributed meanings or overlapping views of ambiguous events. These more robust definitions are informative to the present study.

Sensemaking: Ongoing

As describe in the "retrospective" section above, sensemaking is a backward look at an ongoing stream of events. In this fifth characteristic, that sensemaking is

"ongoing," Weick (1995) explains, "Sensemaking never starts. The reason it never starts is that pure duration never stops. People are always in the middle of things, which become things, only when those same people focus on the past from some point beyond it" (p. 43). An example of this characteristic would be a physician talking with a new patient. The physician will ask questions about the patient's health. The patient will likely start his or her story with the onset for the medical encounter at hand. The conversation focuses on one specific point in time as a beginning, but there were events leading up that point. Doctors, who have limited time even with new patients, will ask questions to focus in on the reason for the current visit. Thus, the doctor and patient can talk specifically about a point in time that is ongoing, even within the conversation.

Sensemaking: Extracted cues

Weick (1995) explains that sensemaking is a quick process where the sensemaker focuses on certain "cues" or events that the sensemaker chooses to highlight. Therefore, Weick urges us to "pay close attention to the ways people notice, extract cues, and embellish that which they extract" (p. 49). He goes on to explain that context is important. Context shapes what cues a person decides to hone in on and context also influences how those selected cues are interpreted. For example, a physician might classify a patient who is not interactive with the physician as "noncompliant" or "rude." Whereas, another physician might determine that the non-interactive patient is uneducated or has a language barrier that contributed to the lack of interaction. Even where the same cue of being "non-interactive" is identified by both physicians, they could have differing meanings.

Sensemaking: Plausibility

Finally, sensemaking is about "plausibility" not scientific "accuracy," although Weick (1995) concedes, "A reasonable position to start from in studies of sensemaking is to argue that accuracy is nice, but not necessary" (p. 56). Weick (1995) goes on to state that "sensemaking is about plausibility, pragmatics, coherence, reasonableness, creation, invention, and instrumentality" (p. 57). According to Weick (1995), plausibility is more important than accuracy for many reasons, including that people must filter data in order to avoid being overrun with information and it is often difficult to tell what is true at the time a person perceives a situation.

These seven characteristics make sensemaking an ideal theoretical framework to help me ferret out the process physicians are going through to make sense of medical malpractice. Sensemaking can add more detail to the present study by highlighting not only what physicians think about their medical malpractice (which could be called their "legal consciousness") but also how they developed their medical malpractice understanding. By focusing on process, this study can avoid the criticism levied against Ewick and Silbey (1998) that they privileged law above other social influences such as institutions (Levine & Mellema, 2001).

As the research shows, physicians' are more concerned about medical malpractice than they should be based on the facts, especially in a tort-reform state like Texas. In order to understand why physicians' perceptions are misaligned with the facts, I will interview physicians. By relying on the theories of legal consciousness and sensemaking, my research will articulate some reasons why physicians' concerns persist.

In the following chapter, the methodology for this study is detailed.

CHAPTER II

RESEARCH METHODOLOGY

In that case, obviously it went nowhere. But it cost my insurance company a lot of money and it caused me a lot of stress because you always equate a suit with "I'm a bad doctor," you know, so you go through the emotional aspects of all of it. *– Doctor Stork*

Being sued is exhausting. Before beginning my work as a doctoral student, I was a litigator at a mid-sized Texas law firm. Most of the time, I represented large, corporate defendants. It was the individual plaintiffs on the opposing side that were worn out. I saw difficult cases drain individuals – both financially and emotionally. Our cases dealt with personal injury and many "treating doctors" were involved either directly or as expert witnesses. The expert doctors could make or break our cases, so I got to know them. We also had to know their backgrounds to make sure they were credible witnesses. Therefore, most of them had little to no personal malpractice lawsuits in their backgrounds. But they often talked about being "afraid" or at least "unsettled" by the possibility of a malpractice suit.

One way to uncover physicians' thoughts is to ask them directly and indirectly in an interview. Hyman (2002) summarizes the medical malpractice beliefs commonly held by doctors:

When physicians get together, the discussion frequently turns to medical

> malpractice. Those participating in such conversations typically hear (and volunteer) a mix of fact, fiction, and urban legends: "Lawyers are out to get you, and patients will sue at the drop of a hat." "If you don't do this test, it will cost you a ton of money and your reputation by the time the legal system is done with you." "Anyone can sue you for anything, and the insurer isn't interested in whether you did a good job or not; they just want to settle the case and move on." "Avoid the poor; they are more likely to sue." "Juries don't like doctors, and they hand out money based solely on their sympathy for the plaintiff." "It doesn't matter what you said or did; what matters is what is in the chart." "If you're nice to your patients, it doesn't matter how badly you screwed up." "Medical malpractice has nothing to do with quality and everything to do with whether the outcome was good or bad." "Once a jury verdict is reported, you won't be able to get privileges anywhere, or malpractice insurance at any price." (p. 1639)[25]

Such thoughts and their origins could be explored by interviewing physicians.[26] Lindlof and Taylor (2011) suggest, "interviews enable researchers to *gather information about things or processes that cannot be observed effectively through other means*" (p. 175, emphasis original). Therefore, interviews were the best method to employ in order to understand physicians' thoughts regarding medical malpractice.

Justification for Qualitative Methods

The questions I seek to answer in order to better understand doctors' fears and

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[25] As detailed in Chapter 1, the research regarding medical malpractice runs contrary to these statements.
[26] It would be difficult to study these interactions except through a retrospective process such as interviewing.

thoughts regarding medical malpractice are best answered by employing qualitative methods. Qualitative methods are useful when researchers want to look beyond the numbers and understand why something is happening. Tracy (2013) explained that qualitative help us "understand and describe meanings, relationships and patterns" (p. 36). Janesick (2003) explains, "The qualitative researcher studies a social setting to understand the meaning of participants' lives in the participants' own terms" (p. 382).

As detailed above, I seek to understand how doctors think about malpractice by exploring the theoretical concepts of legal consciousness and sensemaking, to answer my research questions. Tracy (2013) suggests that qualitative research can span disciplines and topic areas. She suggests that qualitative methods can be used to understand: the self, relationships, groups and organizations, cultures, and mediated and virtual contexts. Therefore, qualitative methods should be used in this study.

Interviews

Interviews were the best methodological approach to answer my research questions because interviews allow the participants an opportunity to share their thoughts regarding malpractice in a confidential environment. Lincoln and Guba (1985) explained that interviews could be "structured" or "unstructured." They define structured interviews as interviews where the researcher has specific questions formulated before the interview and the participant is asked to answer those questions. In an unstructured interview, the participant provides the questions and answers throughout the interview process.

Tracy (2013) similarly described interviews as being either structured or

unstructured. She explained that structured interviews follow a list of questions that are asked in the same order for each interview. According to Tracy, structured interviews are best employed when comparing and contrasting information from a large number of participants. However, structured interviews lack "flexibility and depth" (Tracy, 2013, p. 139). Unstructured interviews, on the other hand, follow an interview guide to help the interviewer start discussions instead of dominating the topics and order of the questions. In fact, the interviewer becomes a "listener and reflector as much as – if not more than – that of the questioner" (Tracy, 2013, p. 139). Unstructured interviews allow for a co-created conversation and understanding of the participant's lived experiences.

I chose to follow a more "unstructured" interview style because I was interviewing a small number of participants and wanted to allow them the flexibility to reveal information in the order they chose. I used an interview guide to facilitate our conversation (see Appendix A). According to Tracy (2013), interview guides are "meant to stimulate discussion rather than dictate it" (p. 139). This less structured interview approach allowed the interviewer to listen and reflect with the interviewee (Tracey). I am confident that the participants experienced our interviews as co-created sessions because two of them said something to the effect that they should "pay me for the therapy session."

Before conducting my interviews, I received approval from my dissertation committee and the Institutional Review Board. For each face-to-face interview, I obtained informed consent from the participant. The interviews lasted between forty-five minutes and just over an hour. This longer time frame ensured that the interview was not

rushed and that participants had an opportunity to expand as needed.

Research Participants

I interviewed physicians from two practice areas – obstetrics/gynecology (OBGYN) and internal medicine (IMED). I interviewed thirteen doctors, with six OBGYN participants and seven IMED participants. I chose these two specialties because they have been used in prior studies, they represent two different levels of risk, and I had access to both groups.

The Majoribanks et al. (1996) researchers included both specialties in their study of discourses from individual physicians and organized medicine. In their study, Majoribanks et al. (1996) labeled the obstetrics/gynecology as a high-risk specialty while internal medicine doctors were considered low-risk.

In a more recent study, Jena, Seabury, Lakdawalla, and Chandra (2011) included both internal medicine and obstetrics/gynecology when examining which specialties are most likely to be sued for malpractice. By reviewing closed malpractice claims from a nationwide insurance company, the researchers determined not only the likelihood of suit for twenty-five different specialties but also what percentage of doctors will make an indemnity payment and the size of payment doctors will make. The claims for 40,916 physicians from 1991 through 2005 were evaluated.

Jena et al. (2011) found that across the twenty-five specialties 7.4% of all

physicians in the study had a claim in a given year.[27] However, only 1.6% of physicians had a claim that led to an indemnity payment to the plaintiff. The doctors most likely to be sued were surgeons – neurosurgeons, thoracic-cardio surgeons, general surgeons, orthopedic surgeons and plastic surgeons take the top five places. On the other end of the spectrum, the physicians that were least likely to be sued are: psychiatrists, pediatricians, physicians in "other specialties" outside of this study, family general practitioners and dermatologists. The research team also looked at the average payment amount to a plaintiff when a given specialist was sued and found pediatrics had the highest average payment followed by obstetrics/gynecology and pathology. The lowest average payment was for dermatology followed by "other specialties" and ophthalmology. The researchers did not explain why the average payment amounts were higher in the former specialties, but it would make sense that younger plaintiffs, such as babies and children, would be cared for by these specialists. These patients would have longer life expectancies and higher "damages" in a legal setting. Therefore, they would merit higher insurance payouts. Another factor that could lead to differing payouts is the type of injury sustained. The researchers did not address this point, but it seems reasonable that except in exceptional circumstances, a dermatologist or an ophthalmologist would not harm a patient to the extent that would call for a high damage award.

Jena et al. (2011) explained that their data indicated that the risk of a claim is independent from the size of an indemnity payment. For example, obstetrics/gynecology

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[27] The Jena et al. (2011) research team operationalized "claim" as any insurance claim and not a lawsuit, although they often go hand in hand. Indemnity payouts were defined as payments made related to a jury verdict or a settlement.

physicians came in twelfth in the list of specialties that are most likely to be sued, but they had the third-highest average payment amount. The researchers also found that obstetrics/gynecology had the highest payment rate per claim at 38%, meaning that more than a third of claims filed resulted in a payment being made. Obstetrics/gynecology also made the top of the list when it came to "outlier awards" – those payments exceeding $1 million. Only 66 payments in the study data reached this amount, which was less than 1% of the payments made. Obstetrics/gynecology accounted for eleven of these 66 payments.

Internal medicine fell in the middle of the specialties evaluated in the Jena et al. (2011) study. Of the twenty-five specialties reviewed, internal medicine ranked as the fourteenth most likely to be sued. The researchers also projected the career malpractice risk for six specialties. Internal medicine physicians are more likely to be sued than practitioners in family medicine and pathology. However, internal medicine physicians are less likely to be sued than general surgeons, obstetricians/gynecologists, and anesthesiologists. Therefore, these specialties appear to represent a high-risk specialty (obstetrics/gynecology) and an intermediate to low-risk specialty (internal medicine).

Further, due to personal connections in the medical field, I had access to doctors in these two specialties. I previously worked at the Texas A&M Medical School which had a relationship with a large, regional Texas hospital (herein referred to as "Regional Hospital"). The position allowed me to work closely with several physicians at multiple locations of Regional Hospital. Second, I have a close friend that is a doctor. She has a wide network of contacts that were used for recruiting.

My sample was one of criterion and convenience (Lindlof & Taylor, 2011). My criterion for recruitment was that the doctor was a certified physician in one of the two specialties articulated above at the time of the interview. I also only interviewed physicians that were currently working in Texas, a state that, as described above, has passed tort reform for medical malpractice lawsuits. Due to the divergence of medical malpractice laws, having doctors practicing in the same jurisdiction was imperative. I also sought out participants that had varied practice types – some in large hospital organizations and others in small, independent practices. As detailed in the findings sections below, the large legal teams supported by the larger organizations influenced participants' responses.

Participants' Demographics

My participants were an even mix of males and females. For the OBGYN physicians, I interviewed three males and three females. In the IMED group, there were four male participants and three female participants.

For age and number of years in practice, the OBGYN group was divided. The three male OBGYNs were older, with an average age of 59.6 and an average 29.6 years in medical practice. Whereas, the three female OBGYN participants' average age was 33.6 and they had an average 3.6 years in practice.[28] The IMED participants were closer in age and years in practice. The male IMED participants' average age was 38.3 and they had an average 6.5 years in practice. The female IMED participants were slightly older

[28] The uptick in females as OBGYNs has been documented by the Association of American Medical Colleges (AAMC). Gerber and Lo Sasso (2006) cited the following from the AAMC: from 1989 to 2002, female OBGYN residents increased from 44% to 74%, while females graduated from medical school only increased 11%, from 33% to 44% (p. 1427).

with an average age of 39.3 and had slightly less experience with an average 6.3 years in practice.

The participants' practice setting varied. Four of the six OBGYNs practiced in a private group that was not affiliated with an academic institution. The remaining two maintained a private practice but also had some affiliation with an academic institution. All of the OBGYNs saw their patients in both the clinic and the hospital. For the IMED participants, all but one were affiliated with an academic institution, and four of those six worked strictly within an academic hospital. Those same four IMED participants were known as "hospitalists," and only saw patients in a hospital setting. Two of the remaining participants saw patients in both the clinic and the hospital while the strictly private practice IMED physician only saw patients in the clinic.

The doctors worked in practices that varied in size. Four OBGYNs worked in a group with at least six physicians that was also part of a larger hospital system. Two of these OBGYNs worked for Regional Hospital. The remaining two OBGYNs worked in independent practice groups with only three and ten physicians, respectively. For the IMED participants, they all worked in groups that were subsets of a larger hospital. Six of the seven participants worked for Regional Hospital.

Finally, five participants had been sued or had received a patient complaint through the Texas Medical Board (TMB) process. The three male OBGYNs had been sued an average of three times and one also received a TMB complaint. For the IMED participants, one male had been sued and one female had received a TMB complaint (see Appendix B for specific participant demographics).

Data Analysis

The interviews were audio recorded and transcribed into Microsoft Word documents. I then coded the transcriptions using AtlasTI (v. 7.1) software. I employed the constant comparison method to ferret out themes from the transcripts (Lindlof & Taylor, 2011; Glaser & Strauss, 1967). I moved through two stages of coding: (1) initial coding and (2) axial coding to connect the identified categories (Lindlof & Taylor, 2011, pp. 250–252; Charmaz, 2006). During my initial coding phase, I used open coding and in vivo coding to categorize the data. In the second phase, I used axial coding to compare the categories to one another and make connections amongst them (Corbin & Strauss, 2007). After identifying the themes, I made another pass through the data to ensure that I had identified all instances of a certain theme.

In order to increase the credibility, consistency, and transferability of my research, I kept notes and reflections throughout the study (Lindlof & Taylor, 2011). I used my notes to keep track of the themes during all phases of the research process, beginning with items that stood out to me from the interviews and continuing to make notes during the coding process. As Lindlof and Taylor (2011) explained, these notes were later used to help me flesh out the identified themes and sub-themes.

Ethical Considerations

As detailed in the interview section above, it was important that I protect my participant's confidentiality. In one of my first of my interviews, a participant expressly said, "And, since this is confidential, I'll tell you…" Therefore, in addition to following the precautions I detailed in my Internal Review Board (IRB) application such as

keeping my interviews locked away, I also chose my words carefully. I did not reveal to my participants what other participants I had spoken with. I also offered to meet participants at places other than their workplaces. In fact, I interviewed three participants at my home. They did not have to schedule time at their offices or answer questions regarding the nature of our conversation.

Another consideration was the "therapeutic" nature of my interviews. Some participants said they had not thought much about medical malpractice and that our conversation made them consider some dreaded possibilities. Others who had been sued for medical malpractice became upset and sometimes angry as they recounted the experiences. I did my best to maintain my role as an interviewer, but often found myself reacting as a friend. While some of these conversations were uncomfortable, I was careful to gather the information regarding my research questions and then move along to the next topic. I specifically avoided belaboring points of sadness for my participants and was able to end each session with professionalism.

And finally, I was careful to respect my personal relationships with my participants. I knew several of my participants in a personal capacity before our interview. If I had personal knowledge about some aspect of my research questions, I made sure that we touched upon those topics in our interview. During the interview process, I was aware of the power dynamic that existed – that participants were willing to listen carefully and answer whatever I asked. Therefore, I did not go beyond my research questions or exploit my pre-existing relationships. I have also maintained strict confidentially for the months following my interviews. I have talked to several of my

participants in professional and personal situations and have been extremely cautious not to mention any aspect from any of my interviews.

Conclusion

This chapter regarding methods should serve as guide to my methodological approach for this study. I have described my process as well as my ethical considerations surrounding interviewing doctors that I knew personally. The next two chapters detail the findings and analysis from those interviews. Hopefully, this background will help situate my role in the process.

CHAPTER III

UNDERSTANDING MEDICAL MALPRACTICE

These things aren't taught in medical school. You know, we're not taught how to be businessmen, let alone how to defend – you know, even how to make a living, let alone then – to then deal with the malpractice aspect of it. *– Doctor Six*

This chapter reviews the findings from research question one that explores how Texas doctors make sense of medical malpractice in Texas and their coping strategies. After coding and analyzing the participant interviews, four dominant themes emerged which answer this question: 1) legal knowledge, 2) personal risk assessment, 3) risk reduction techniques, and 4) coping mechanisms. For their legal knowledge, participants identified two specific areas of knowledge – tort reform and characteristics of the overall legal system. The personal risk assessment theme varied by specialty, but all participants were able to express instances when they have heightened malpractice concerns and feelings of a lack of control when it comes to medical malpractice. All participants suggested risk-reduction techniques that can be classified as communication skills, patient management skills, and documentation skills. Finally, coping mechanisms fell into two major categories: feeling insulated and admitting limitations. I discuss each theme and the related sub-themes in turn below.

Legal Knowledge

Knowledge of Tort Reform

The first theme that emerged was participants' knowledge of tort reform. When asked about the current state of medical malpractice in Texas, all participants mentioned tort reform specifically. However, his or her degree of knowledge varied greatly.

For the OBGYN group, the three less experienced, female doctors knew the tort reform basics. Dr. Rockstar explained that she understood that it was better than it had been before tort reform and that "most physicians are very happy with some of the reform that took place." Therefore, she, like the other three younger OBGYNs did not have extensive knowledge of tort reform or its history. She did note that OBGYNs have a high risk of suit and that it is now more difficult for patients to file suit in Texas, but she was unsure of the underlying reasons:

> ... I think your risk [as an OBGYN] is high, but I don't think most people go through with the actual suit. And I don't know why that is. I don't know if it's because it takes a lot of effort to find a lawyer and then you're paying that lawyer to gather information, and then... I don't really know how that whole process works, if people are paying a lawyer and they gather information and then they tell them, hey, I think this... you have a good case here.

The other two young OBGYNs also discussed the difficulty of filing a lawsuit. Dr. Bento noted that Texas lawyers will no longer take frivolous lawsuits. And Dr. One said, "it's just a pain to sue someone... I feel like you have to *really* hate a doctor or they had done something *really, really* bad to bring ... to start that process" [emphasis original].

The three male OBGYN doctors, who had been in practice for many years, knew more about tort reform than any of the other participants; they shared information about the history and ramifications of tort reform. Dr. Stork demonstrated the deepest understanding of tort reform and how it came about in Texas. He began by explaining that Texas tort reform is the "model for the rest of the nation." He went on to say, "Legislators have been very aggressive because Texas has a very business-friendly atmosphere and that carries over into medicine as well." He even knew the underpinnings to the previous tort reform in Texas, which was passed in the 1990s. He explained, "So the initial tort reform was, uh, you know, was to get away from the venues and that helped a lot." Dr. Stork also noted that it is more difficult for lawyers to take medical malpractice cases post-tort reform. He said, "Since there's skin in the game, you only get those [lawsuits] that are clear, you know clear evidence of negligence."

Dr. Obg, similarly, knew a great deal about tort reform. He explained, "tort reform has greatly reduced the number of junk lawsuits." But he also acknowledged that tort reform has "probably discouraged some cases from being filed that probably had some degree of merit." Dr. Obg also noted that Texas lawyers are unwilling to take on medical malpractice cases following tort reform due to the damages caps. He explained the difficulty plaintiffs have finding a lawyer as well as the effect that tort reform has had on frivolous lawsuits:

> If you're a defense lawyer, most of them now are having to work under a budget. Uh, which inevitably they're cutting corners if they're going to make any money

> with their client, and I don't think clients know that. Um, the, the plaintiffs' attorneys' mentality when there was no significant tort reform was, 'I'm going to go ahead and try to do all ten of these cases because I know one of them I'm going to hit a home run on that will cover my overhead on the other nine. Well, now, uh, you can't, uh, you can't make enough money off a big case now to cover all those others, and so…it's been a good thing. They're not taking the, the crap cases anymore. I hardly ever see a case now that I think, 'This is absolutely ridiculous. Why would anybody file this case.' Every case that I look at now has some degree of merit, which I didn't feel that way ten years ago.

When asked where he got this understanding of tort reform, Dr. Obg replied, "I know everything about it…I lived through it."

Dr. Six, the third experienced OBGYN, also knew a great deal about tort reform. He explained not only the basics of the law, but also how it affected Texas Medical Board (TMB) complaints:

> The two things that have happened... one's a very good thing and that is … there's caps. Uh, it's harder to sue the physicians, which has taken the super-scare, that you know, they're going to sue and win $50,000,000, that, that cripples the clinic in an organization, so everyone's panicked over that, so that's gone. The second part to that is, as a consequence of giving up ... and this is how I understand it ... giving up the large pay-outs and some of the fees of suing physicians, the [TMB] has increased their reporting of more minor things. So you, we have now just a huge number of patient complaints, and all patient

> complaints to the [TMB] have to be investigated, and so that process, in my opinion, has turned out to be 'guilty until proven innocent.'

Dr. Six's thoughts about the TMB were echoed by Dr. Obg. In the last lawsuit filed against Dr. Obg, the patient also filed a TMB complaint. He agreed that regardless of fault, he expects that the TMB will assign him some degree of fault. He said

> The Texas Medical Board is a zoo, and ... inevitably I'll probably end up paying some fine and having to get 20 hours of CME [continuing medical education]... Well, I've reviewed several cases for physicians and the claim was, you know, to the board, and so I've been down that road also. And to my astonish– just astonishment, uh, there's, if there's a complaint, there's a fine…and, and the length of time it takes for them is ridiculous.

These experienced OBGYNs knew not only about tort reform, but expressed a deeper understanding of the overall malpractice history and landscape in Texas.

The IMED participants knew less about tort reform history than the experienced OBGYNs. The reason for this divergence was probably due to experience, since as Dr. Who explained, "I've been practicing most of my career post tort reform." However, most of the IMED doctors still understood the tort reform basics.

Dr. Washington and Dr. Luke both generally knew that there were damages "caps" in Texas following tort reform. Dr. Fields knew specifically that tort reform "put a cap on pain and suffering." Dr. Fields went on to say the caps "helped a lot because I think that, um, the number of lawsuits probably decreased." Dr. Adams was certain in his broader explanation:

> After tort reform, I know that, um ... premiums have come down, to some degree, and it kind of depends upon who you ask, but I believe the ... I believe the generally accepted numbers indicate that the number of suits have declined after tort reform has been instituted.

Dr. Washington indicated that tort reform has led to less frivolous cases while meritorious cases still go forward:

> I don't think all of the legitimate lawsuits have been, um, weeded out or discouraged through tort reform. I think, at least the, in my opinion, I don't know that much about law, but in my opinion, I think it helped to, to taper the, some of the frivolous lawsuits without, uh, hurting, you know, legitimate claims from coming through. It put a cap on the amount of money that someone can get, like somebody who's just doing it for money. It makes them think twice.

And finally, Dr. B expressed a general understanding of medical malpractice that "it's probably better in Texas than it is in states like New York, Illinois, California."[29]

As indicated above, all participants mentioned tort reform. The only one that did not expand on this was Dr. Sabrina. She was indifferent to tort reform due to her affiliation with Regional Hospital. She said, "Honestly, I really don't know. I just know that ... I think there's a cap, and I don't, honestly pay much attention to it, because I'm covered here." Dr. Sabrina identified her employer as a reason for not knowing much about tort reform, but it could also be because of her practice as an IMED physician.

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[29] It is unclear why Dr. B cited these states specifically. In fact, California has the same $250,000 cap on noneconomic damages as found in Texas tort reform (see footnote 4 above & Becker, n.d.).

From Dr. Sabrina's statement to the experienced OBGYNs extensive knowledge of tort reform, the participants' knowledge of tort reform varied significantly. What is significant is that when asked about the state of medical malpractice in Texas, each participant began his or her response with an explanation of tort reform in lieu of any other topic, such as a prior lawsuit or specific malpractice situation. Therefore, their knowledge of tort reform was the first answer that came to their minds. However, as illustrated above, the accuracy and depth of knowledge varied greatly among the participants.

Explaining the Legal System

The second legal knowledge theme identified was the participants' understanding of the legal system. Three main "truisms" about the legal system were articulated by the participants: (1) it is "stressful," (2) it is "confusing or foreign," and (3) it is "inconsistent." Participants from both specialties articulated these points, but as detailed below, the OBGYNS gave more information.

The OBGYN participants spoke about the stress surrounding a lawsuit. Dr. Obg, who has been sued, went all the way to trial for a case filed against him early in his career. He was so stressed by the case that he suffered physically. He explained,

> I was taking every drug known to man to help with reflux and this, that and it never got better. And the day after the trial was over, it was gone. And I would have never in my life thought it was a stress-related, uh, anxiety issue. But it was, and it was impressive. I mean, literally the day after that trial settled, I never had another. I had never had abdominal pain prior to that… I had no idea

how much stress that was creating for me.

Dr. Rockstar, an OBGYN who has not been sued, shared that she was stressed about even the possibility of being sued. She said, "And the folks that I have talked to, even now in practice, who have gone through a suit, say it's one of the most horrific experiences to ever go through." She goes on to admit, "Maybe in my head, it's worse than it really is."

The IMED participants, though less direct with their comments, also expressed a feeling of stress surrounding a lawsuit. Dr. Who, an IMED doctor who had not been sued, was asked if she has a fear of medical malpractice. She responded, "I think it's something I'm aware of, and the idea of being involved in a suit, yes, it is fear-inducing." Dr. Washington, who was sued early in his career, explained his thoughts after being sued,

> I was worried that I would be, you know, stuck in this ... I would have, first I'd have a black mark on my record from the get-go, and if I lost this job, it would be very hard to find another. And, um, I just didn't want my new boss to think badly of me. And, uh, and, you know, who knows? I could have been sued for a lot of money or, you know, um, and I already had a lot of medical school debt and so I didn't want to start, you know, 10 steps back, 10 steps behind for the beginning of my career. So I was starting out my career with a bad taste in my mouth, basically. Almost made me, almost made me not want to be a doctor.[30]

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[30] Although there is not a great deal of research regarding doctors' reactions to being sued, Sara Charles and her colleagues focused on this topic in the mid-1980s. In Charles, Wilbert, and Franke (1985), the

Dr. Washington said it took time for him to feel less stressed about being sued.

Several participants expressed confusion surrounding the legal system or a feeling that it was foreign to them. Dr. Rockstar, an OBGYN who had not been sued, identified the legal process as foreign. She said, "It's very stressful. And you feel like, all of a sudden, you're in an environment where it's somebody else's world." She continued to explain her thoughts about lawyers and a lack of legal training for doctors,

> And they know how to take your words and use them against you, and you don't know. That's not your world… lawyers and court and documents and how it gets used against you, in legalese and all that, it's just not what we're trained….other than to be aware of it. But we're not really trained in it.

Dr. Six also found the legal system to be foreign. He said, in a jovial tone, "But uh, no we don't really, we didn't, we didn't get no training in legal matters."

Dr. One, an OBGYN who had not been sued, spoke the most extensively about a confusing legal experience she had while in residency training. She recounted,

> I was involved in one case in residency and they actually never gave me any suggestions. They gave me a letter and said I was supposed to show up. Didn't tell me the patient, didn't give me any heads up, and then I showed up and got grilled for two hours. And they never told me anything before or after. I don't

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researchers surveyed 355 physicians in the Chicago area about their reactions to a medical malpractice lawsuit. They found that 56.1% of those 355 physicians had been sued. One of the significant differences the researchers found between sued and non-sued doctors was related to "quitting." The researchers found that the sued physicians were more likely than non-sued physicians to make the following changes to their practices: (1) to stop seeing "risky" patients (48.9% sued versus 29.5% non-sued); (2) to think about retiring early (42.9% sued versus 30.3% non-sued); and (3) to discourage their children from pursing medicine as a career (32.0% sued versus 19.0% non-sued). Charles (2001) went on to review steps that doctors can take to cope with being sued.

even know what happened with the case.

She explained that neither her supervising physicians nor the hospital legal team explained anything to her before the hospital lawyers interviewed her. When asked for more details, she said,

> It was very strange because like I said they didn't tell me who it was about before I got there and I think it had been eight months prior when the experience happened. When I got there I was trying to remember the patient and I remember the patient vividly, but there were two patients in one night that were very similar, same story, both had twins, like they were very similar. I think I delivered 14 or 15 babies that night and the computer system had shut down. So we were paper charting. There were a lot of things that had gone wrong that night.

The confusion was never clarified for Dr. One. Years later, she is still unsure about the situation:

> I didn't know my rights. I didn't know that I was supposed to know. No one told me anything. I know that there was a medication that wasn't administered properly by the nurse. There was a tubing issue with an IV, and it literally was running onto the floor. I think ... I know I found that error and I reported it. So, I didn't know if I was in trouble. But when I reported it, I had to go to the operating room so I didn't know what happened with it. I don't know if someone tried to cover it up but I reported it, so I know I did what I thought was right, you know?

After a situation like this, it is understandable that Dr. One finds the legal system confusing, and like the others, she feels that it is "foreign territory."

For the IMED participants, they also expressed confusion regarding the legal system. Dr. Adams, like Dr. One above, had a confusing ancillary encounter with the legal system. He explained, "One instance where I wasn't sued, but had to go testify in court one day, with no prior warning." He had just been assigned to a patient that morning and was asked that same day to go testify in court. He explained,

> I had no idea what to expect, other than what our attorney told me on the way over there. I mean honestly it wasn't a…it wasn't a bad experience, it was just a nerve wracking experience. I didn't know what was coming. I mean I was like…I had no idea what was about to happen. And yeah, uh, it was ... it was nerve wracking.

Dr. Adams admitted that this situation was unusual, but due to the rotating nature of their tertiary care center, it can happen. Notably, Dr. Adams was not sued but still found the legal atmosphere "nerve wracking."

Another IMED doctor had similar sentiments. Dr. Who, who had not been sued but had defended a TMB claim, said lawsuits were a "pain" to deal with. She explained,

> …feeling like it's gonna take a lot of time and be a very foreign type of environment to deal with, because we're not familiar with the legal system…um, and, um, feeling like medicine is so complex to practice that, uh, any patient I take care of, you could potentially punch holes in, in what I've done for the day, depending on what you were trying to prove.

Dr. Who found even the "idea" of being sued stressful. She also echoed the sentiments that the legal system is a "foreign environment."

Finally, several OBGYN participants explained that the legal system is inconsistent when it comes to medical malpractice.[31] Dr. One identified inconsistencies in which doctors are sued, "You can be a terrible doctor and get away with it or you can be a great doctor and get in trouble for it." Dr. Obg thought the hospital system, not the legal system, weeds out "bad" doctors. He said,

> I think that what happens is, is the hospital system weeds them out. Uh, because, you know, if you have an egregious problem … and particularly if it's a doctor that's had more than one, well they just take away his privileges from the hospital, and that ... But, but the legal system I don't think ever does that."

And finally, Dr. Rockstar expressed concerns over having lay people make decisions regarding medical malpractice, "When it comes to medical stuff, hopefully a jury would not be involved. Because I think it's ridiculous to have twelve non-medically trained jury members making a decision on something that you can only understand if you're medical."

The participants expressed varying levels of legal knowledge. They all reviewed their understanding of tort reform. As for additional knowledge, they shared what they understand about the legal system. They find it to be stressful, confusing or foreign, and inconsistent. With those thoughts about the legal system, it is understandable that they

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[31] The participants did not discuss the consistency differences, if any, between the legal system and the TMB administrative process.

do not want to be involved in the legal system.

Personal Risk Assessment

Not Worried vs. It's On My Mind

When asked about their personal medical malpractice risk, a two-part theme emerged. One, many participants were simply not worried. The other part indicated that medical malpractice was prominently on some participants' minds. As detailed below, these themes were not mutually exclusive.

The experienced OBGYNs and IMED doctors were not especially worried about medical malpractice. The three experienced, male OBGYNs did think about it, but their level of concern was low. Dr. Stork explained, "I think about it, but, but I feel like the frivolous stuff that you would just always fret about is just, you know, I just don't worry about it too much anymore." He goes on to explain that he focuses on other business-oriented concerns:

> It's, it's one less worry, but you know, but your worries go from one to the other. I'm worried less about malpractice than a $71,000 premium, but I'm worried more about Medicaid and Medicare cutting back on the reimb-, on the Blue Cross/Blue Shield cutting back on the reimbursements, you know. So I mean that's just life, right? You go from one to another.

Dr. Obg had similar sentiments: "I can tell you on a daily basis I don't even think about medical malpractice. It is not an issue for me or my partners ... Even with this case that, uh, just started going on." He went on to offer his business-minded explanation for his lack of concern:

> Well, A: We have very few cases against us and B: The cost is trivial to the cost of my operations, uh …My malpractice insurance is 7 or $8000 a year…my monthly overhead is $100,000. So, you know 1.2 million of overhead, and I'm paying ...Seven thousand dollars for malpractice insurance?

Both Dr. Stork and Dr. Obg, private practitioners, offered business-oriented reasons for not worrying about medical malpractice. When Dr. Six, a Regional Hospital employee, was asked if he thought about medical malpractice day-to-day, he simply replied, "Nah. Used to, not anymore." He went on to explain that he had been sued and come to realize that it was not about him personally; it was about "just money." Perhaps such realizations helped all three experienced OBGYNs (all who had sued for medical malpractice) have less concerns.

All seven IMED doctors were not that concerned about medical malpractice. Dr. Sabrina simply said, "I just ... I don't think about it that much." Similarly, Dr. Washington explained that even after being sued before, "I'm not usually worried about malpractice. Um, even this guy that was escorted had threatened to sue, but I wasn't worried about it."

Several of the IMED doctors offered more explanation surrounding their lack of concern about medical malpractice. Dr. B and Dr. Luke both considered themselves to have a low risk of being sued. Therefore, they do not really worry about malpractice. Dr. Who said that being in practice for eight years and only having one TMB complaint that was subsequently dismissed helped alleviate her worry. She did express concern about malpractice in her current administrative role:

> I don't necessarily think of it daily…um, I would say weekly. And then since I'm division director for the group, I do think about it in terms of just protecting the group, like, what are the processes we need to have in place that are like, we always do this – as a group. It's a general practice; you know what I'm saying? So that it makes things more defendable, in the future.

Two IMED doctors did tie their level of concern to the patients they treated. Dr. Who admitted that her worry "depends on the patient," but she did not elaborate. Perhaps Dr. Adams' explanation helps illustrate the point:

> The only time I really think about it [medical malpractice] day-to-day is, uh ... is when somebody's starting to get real ... like they start throwing up red flags. They're just mad. And they've been wronged and they're out to get somebody, and ...Then I start thinking about it. Otherwise I don't think about it.

These, and other heightened concerns, are discussed in more detail below.

Finally, Dr. Fields not only expressed a lack of concern about medical malpractice, but also was adamant that she could not imagine being sued. She explained,

> I would find it hard to believe that I would be sued…If you always do your best and you always do things to the best of your ability – without cutting corners, without trying to fly through things – then I would find it hard that [a lawsuit] would happen.

Although her IMED colleagues did not share Dr. Fields' bold attitude, they were overall not very worried that they would be sued for medical malpractice.

The second personal risk theme that emerged was that medical malpractice was

always on some participants' minds. While three IMED participants mentioned this theme, all six OBGYN participants talked about it more extensively, with many using the same phrasing.

The three IMED physicians that discussed this theme spoke about it more generally than the OBGYNs. Dr. Adams said,

> Most of the time there's a little thing in the back of my mind that I'm worried I might be sued, but then I ... I look back at everything that's happened, and think to myself, you know, did we do anything wrong? Could I have done something different? And most of the time the answer is no.

Dr. Who similarly said she thinks about medical malpractice, "I feel like it's been better than what it was prior [to tort reform], in general that's my perception. Um, but, uh, I think there's still a significant fear that physicians have about [being sued]." And finally, Dr. Luke explained that although his medical malpractice risk is low, "I guess what always sticks in the back of your mind, even though you think it's low, you know, you never know, I mean, I do see sick people, and so sick people have bad outcomes."

The OBGYNs consistently said that medical malpractice was on their minds, but gave qualifications. Even the experienced OBGYNs that all reported not being worried, admitted that it was on their minds. Dr. Stork explained, "I think it's always in the back of your mind, but like I said, it's not near like it used to be [after tort reform]." Dr. Obg also said he thinks about medical malpractice "Every single day." He expanded with additional details,

> Every single chart that I write, I know that I have to put the right wording in it, so

> it couldn't be construed differently ... uh, it might, might suggest that I was not paying attention to something. Now I have a scribe… she's not a physician, she doesn't understand the medical malpractice side of things. She doesn't understand the liability, so I have to go back in and edit the wording because the way she's worded it leaves me vulnerable, and I think about that on every single chart that I sign off.

Finally, when Dr. Six was asked about medical malpractice, he said, "It's always running in the background." He explained that OBGYNs learn through training that medical malpractice is important for them, "We have more vulnerability and so our… through residency and practice…the unofficial curriculum, the hidden curriculum is the malpractice thing. We learn that through, sort of, to the side. With no lectures, no formal training." It seems that this informal training was successfully passed along to the younger, less experienced OBGYNs.

The three less experienced OBGYNs said that medical malpractice was always on their minds. Dr. One reported that she thinks about her medical malpractice risk "constantly" due to the extreme situations she has dealt with during her training and practice. Following her comments regarding the inconsistencies in the legal system, Dr. One followed up with, "…you have to almost cover your butt all the time." Dr. Bento summarized her thoughts, "Because I think there are some people that you can't please. And you know, I think that there are some people that will maybe just sue to sue, and that's always in the back of my mind." When asked if she is concerned about being sued, Dr. Rockstar also said, "It is always somewhere in the back of my mind, yes." She

expanded:

> It's a terrible environment to practice in, to be honest…The "malpractice environment," seriously. You shouldn't have to practice ... I don't think we should have to... to bear this weight of always being afraid you're going to get sued.

Clearly, medical malpractice concerns dominated the responses from the three less experienced OBGYNs more than the experienced OBGYNs and the IMED participants.

To summarize, the experienced OBGYNs and all IMED participants were not too worried that they would be sued for medical malpractice. The experienced OBGYNs gave business-oriented reasons for not being concerned. The IMED doctors correlated their low level of concern to being in a low-risk specialty and to practicing in a protected environment. On the other hand, all of the OBGYNs expressed having ongoing thoughts about medical malpractice. Despite their business-minded explanations that they were not that concerned about medical malpractice, the experienced OBGYNs admitted that they still thought about their medical malpractice risk – that it was part of the specialty and was indirectly taught to new OBGYNs. The less experienced OBGYNs reflected that sentiment in their comments; all three kept medical malpractice concerns "in the back of their minds."

Heightened Concerns

No matter their level of medical malpractice concern, the participants had heightened concerns with certain circumstances or patients. Bad or unexpected outcomes caused the participants to worry more about medical malpractice. Dr. One, an OBGYN,

explained, "When something happens I'm more scared that a suit will be brought or something." Dr. Rockstar, another OBGYN also said,

> I don't think about being sued *all* the time, but it's always in the back of your head, more so when, you know, bad things happen. The unforeseen things, I should say, like that, that you don't want to happen, happen.

The IMED participants also worried more about medical malpractice with bad outcomes. Dr. Adams explained that he goes over the case in his head when a bad outcome happens to think about what he could have done differently. And Dr. Washington said he pays more attention to negative situations.

The participants also expressed increased concerns with certain patients. For the OBGYN participants, only two talked specifically about patients they worry might file suit. Dr. Bento said she identifies litigious patients, "You can just tell, just the way their mannerisms and if they talk about suing or I saw this doctor and they were bad and…or if they're going through a lawsuit." Dr. Rockstar said, "Uh, I think, and I don't know if this is true, but it is my impression that folks that don't have a lot of money are more likely to sue."[32] She went on say that she is also concerned about "very unreasonable patients" or those "with language barriers … because even with the translator, I don't know what the translator is translating." Overall, she explains that it boils down to anger, "I think the person that sues is a person that thinks they were wronged. And they're mad,

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[32] Research has shown that doctors perceive that poor patients are more likely to file suit (McClellan, et al., 2012). In fact, OBGYNs have specifically been shown to hold this bias (see Bulger & Rostow, 1990) citing Institute of Medicine (1989)). As shown above, the poor are less likely to file suit that higher-income patients (see Burstin et al., 1993; McClellan et al., 2012).

and they're going to pursue it."[33]

The IMED physicians also identified patients that they felt were more likely to file a medical malpractice lawsuit. Several of the IMED doctors said that unhappy or angry patients are the ones they feared. Dr. Washington said that he becomes concerned when a patient is unhappy. Dr. Sabrina explained, "I think angry and demanding leads to suits. Or threats of suits." Dr. Fields echoed these comments:

> Most of those patients who choose to sue are doing so because they are angry, hurt, or upset. A lot of times I don't think it has to do with negligence…Let's say you can get sued when people are angry, hurt, upset, this and that. That's the first thing that triggers a lawsuit.

Other doctors identified more specific characteristics that they thought made patients more likely to sue. Dr. Adams and Dr. Luke said that patients who are "skeptical" are more likely to file suit. Dr. Adams clarified that he appreciates patients who ask questions, but he is concerned about those that do so "almost to provoke you." Dr. Luke gave the following explanation:

> I mean there's people, patients with unrealistic expectations. And that always want an answer and there's not always an answer in our world, and those type of things, and so they can be the more difficult patient, and they want all the information. So they may be more likely to be skeptical, but I think that comes from their own skepticism going in.

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[33] I have not found research to supports the assertion that plaintiffs are angry. Huycke and Huycke's (1994) study of potential plaintiffs calling into a lawyer's office found that more than half of their participants cited a poor relationship with their doctor that preceded the alleged medical malpractice.

Both Dr. Adams and Dr. Luke think that this skepticism could lead to a lawsuit.

Like Dr. Bento mentioned above, Dr. Adams and Dr. Luke both said they also believed that patients who had previously filed lawsuits are more likely to sue again.[34] Dr. Adams said,

> Honestly, I believe that most of the people who ... most of the people that have been involved in a bad experience and sued and had that mindset of, "yeah, something bad happened…I would just go right back"… I think that's the personality of that person. I don't know if that's true or not.

Dr. Luke expanded this concern to include patients who had family members who had previously filed a medical malpractice lawsuit. He said, "I've had patients tell me that, you know, they, that they've talked to their family member and says we should sue because of X, Y and Z."

Finally, Dr. B expressed identified low-income patients and those with a low education levels as more likely to file suit. He said,

> I do have the low income or the low educational consumer, who I always wonder if you know if, if something went bad, would they come back and hold me accountable to-to some standard that, um, no one could really meet. I do think about that.[35]

Although the participants were quick to identify patients that they thought were more

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[34] May and Stengel's (1990) study supports this statement by finding that patients that sued their doctors were more likely to have prior experience with litigation than the patients that did not file suit.

[35] Again, poor patients are less likely to file suit that higher-income patients (see Burstin et al., 1993; McClellan et al., 2012). May and Stengel (1990) found that the patients who filed suit against their doctors were less likely to have health care or legal knowledge; however, the researchers did not address an overall level of education.

likely to file suit, they did not cite to any evidentiary reasons for these characteristics. While some were recalling specific patients who had sued them, the remaining participants relied on their perceptions of patient interactions. It was clear that certain situations and patients caused the participants to think more about a possible medical malpractice lawsuit.

Out of My Control

Despite their level of medical malpractice concern, the participants expressed an inability to prevent medical malpractice lawsuits. As discussed below, they explained efforts to reduce their medical malpractice risk, but there remained an underlying sense that mistakes and lawsuits are inevitable and that some things were out of participants' control.

As for mistakes, the participants readily admitted that mistakes are made in medicine. The OBGYNs qualified their comments. Dr. One said, "If I make a mistake…" while Dr. Obg said, "I may make a mistake…" and Dr. Six said, "I might've made a mistake." The IMED doctors were more up front in openly admitting mistakes. Dr. Sabrina outright said, "We're all going to make mistakes, right? We always make mistakes." Dr. B, another IMED physician said mistakes happen. He explained, "It's almost like Murphy's Law, if it can happen, it will."

According to the participants, not only are mistakes unpreventable, so are medical malpractice lawsuits. The OBGYNs expressed this theme in their comments. The three experienced OBGYNs had all been through at least two lawsuits, so being sued was a reality for them. They explained that it was futile to worry about lawsuits

because certain things are out of your control. Dr. Obg explained that lawsuits are unpredictable; doctors can do everything that is best for the patient and still be sued. He explained, "That's why I'm paying for insurance." Dr. Stork had a striking example of how difficult it can be to predict what situations could lead to suit. He had been sued once for doing a cesarean section too soon and had another suit for doing one too late. He explained,

> You can't do a C-section too soon, you get sued. You can't delay it any, you get sued. You know, so you still just do the same thing … And that is what is confusing to you 'cause you…go how would I have done something differently and at the end of the day, you go, I couldn't have, so you just…okay, have at it.

Following the second lawsuit, Dr. Stork explained that he tried not to take being sued personally because "it's part of the system."

The third experienced OBGYN talked specifically about a lawsuit following a patient's death and his inability to control the outcome. Dr. Six explained,

> I think back and go, you know what, I might've made mistakes, I did the best I could at the time, bad things sometimes happen. I'm gonna to die, she's gonna to die, we're all gonna to die. When I get to heaven, I think she'll be okay with it.

Dr. Rockstar, a less experienced OBGYN had similar sentiments regarding control,

> It's just kind of my life view and... you know, this life is short, and what's the worst thing that could happen to me? You could sue me, you could take everything away, but, I mean, really, you're not going to like execute me. You know what I'm saying? So, I just kind of, I guess, put things into perspective.

> And you know, I have faith, I'm a Christian, so I feel like, you know, God will take care of me. It doesn't mean I won't be sued or I may have... may not have to go through that long process, but it... I just kind of resolved myself that if that happens to me, I'm just going to take it as a learning opportunity to be a stronger, better person and learn how to forgive people and not be angry. And so I just kind of resolved it to that.

The OBGYNs were "resolved" that they are unable to control their medical malpractice fate.

For the IMED participants, they also noted that lawsuits are inevitable. Dr. Fields, who had not been involved in a lawsuit, explained, "I've been told [I haven't been sued] because [I] haven't practiced long enough." When asked if she believed this was true, she said yes, but then qualified her answer with finding it difficult to imagine a situation where she would be sued. Similarly, Dr. Adams expressed a belief that he could do everything correctly with regard to patient care and that he could still be sued. He had not been sued but explained, "I think I've done everything right and I think everybody else that's taken care of the person has done everything right. So, you know. Come as it may." Dr. Luke, another IMED physician who had not been sued also felt that lawsuits were possible, "It's just, things happen, you know. I mean, I get along pretty well with my patients, I really do. I mean, there's always a few everywhere, and so that's why I'm saying, you know, nothing's 100%." Another IMED physician who had not been sued, Dr. Sabrina, simply explained, "I expect to be sued."

Dr. Sabrina voiced her lack of control over potential lawsuits and their

inevitability, “I can’t do anything about it. I can only take care of my patients, to the best of my ability. And if it happens, it happens. And it will happen. And I just have to worry about it then.” Dr. Sabrina also spoke about trying to make patients happy. She ultimately learned that she could not control patients’ reactions:

> You can’t control how someone reacts. I don’t think that I appreciated that in the beginning. I think I wanted to make everything perfect, and I think that I wanted everyone to be happy, and I wanted everyone to like me. Now I can only adjust to what I think the patient or the family needs. And either it’s effective, or it’s not effective. But I can’t control it.

Like Dr. Sabrina, Dr. Washington, an IMED physician who had been sued, spoke specifically about an inability to prevent lawsuits. He said he tries to provide the best care to his patients by treating them like family, but “then the rest is, you know, out of your hands.” He continued,

> But um, if somebody’s gonna want to sue, they’re gonna sue… they’re kind of a different breed of consumer, uh, a medical consumer. I mean, it’s not like they’re buying, um, a product. They demand more than just your average consumer does…it’s just nearly impossible to make everybody happy.

The inability to make patients “happy” was a concern for the IMED doctors and led to a feeling that they lacked control in medical malpractice situations.

Dr. Who, an IMED doctor who had not been sued but had a TMB claim filed against her, also talked about a lack of control. She said,

> I think a lot of it is being, um, one, feeling like someone doesn’t like you, that

> you have a patient who's upset with you for some reason, whether there's a good, or, good reason for that or not. Um, feeling like you have no control over that situation.

She went on to talk more about how she handles a lack of control:

> So some of it is my faith. That okay, yes, this may happen, but what people may think of me, you know, yes I want to be a good person, I want to make good decisions, I want to take good care of patients, I want to stay up on my medical knowledge, but at the same time, I can only control what I can control, and beyond that, it…in the end, it's just a life situation…

The participants had a fatalistic outlook about mistakes and lawsuits. Many expected to be sued, even those who estimated their overall risk as "low." Despite expressing thoughts that lawsuits were inevitable, the participants still took measures to prevent them as explained in the following section.

Risk-Reduction Techniques

Communication Skills

The first medical malpractice risk-reduction technique identified by the participants was using good communication and building rapport with their patients. Several OBGYNs explained that they had been taught that communication was a risk-reduction tool. Dr. Rockstar said, "The biggest thing that I have been told in residency is that communication is very important." Dr. One also explained that she had been told "people are less likely to sue if they like their doctors, if they're friendly." And Dr. Bento said, "I noticed if you have a really good rapport with your patients, you're less

likely for [a lawsuit] to happen."

The participants specifically discussed apologizing for mistakes as a communication technique. Dr. One talked about apologies along with other communication issues:

> I remembered hearing if you apologize ... I don't even remember where I heard this, but if you apologize, if your patients like you, you're less likely to get sued. And then I remember hearing some statistics that most of the doctors that get sued are the people that are just really rude to their patients and don't talk to them and don't look them in the eye. Then the further I got into medicine, the more I got to see these doctors that I feel like they were probably the ones that got sued.

Dr. Six also explained the importance of apologizing:

> And then if things do happen, no more hiding around or chipping around at it. I am so sorry. Lay it out. Tell them, 'Sorry, I can't believe this, I'm probably… it's probably my fault, you know. I just feel so bad about it right now, I'm going to try and do everything I can to make it better.' And I think [hospital administrator] mentioned one time, he goes, probably [Dr. Six's] talk has saved us 10-15 lawsuits on bad things that happened and people just seem to be real happy.

The OBGYNs that discussed apologies clearly believed it was an effective communication strategy to avoid medical malpractice lawsuits.

IMED doctors also mentioned apologies. Dr. Sabrina said, "I think that the hardest thing to do, as a physician, is to admit a mistake. But that's also our ... um ...

biggest shield." Dr. Adams explains how the importance of apologies:

> Honesty with patients is usually a big theme. Including going in and saying, um, you know, this is what happened ... uh ... I'm really sorry that happened, and just being very upfront, and not trying to hide anything from people ... from patients.

Dr. Washington explained the necessity to apologize, even for the actions of others:

> You can do everything from the medical standpoint perfectly, but if they're not happy with a meal or the air conditioner is not working right, or the nurse doesn't answer the call button quickly enough, they're unhappy, and then you walk into a hornet's nest and you spend a good part of your day apologizing for things you didn't even do. But you're part of the [Regional Hospital] team, and image is everything and we are providing a product. Um, it's not just medicine, it's the whole experience.[36]

It appears that Regional Hospital has made apologizing part of its risk-reducing plan because two other Regional Hospital doctors mentioned it as well. Dr. Who said that her team always apologizes and she pays special attention to make sure the doctors talk with the patients in a timely manner. Dr. Luke echoed Dr. Who's comments:

> [Regional Hospital] want[s] everybody to be right upfront about it. They're very proactive in that, because I … I'm glad you mentioned that … because they absolutely said that, that we tell everybody upfront…It's just like anything, if

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[36] Although no research was found regarding the correlation between how genuine an apology is and its efficacy, there has been research conducted regarding states that have apology laws where an apology by a physician is excluded from evidence in the event of a trial. Ho and Liu (2011) found that states that had such apology protection for physicians had a $32,342 (or 12.8%) decrease in malpractice payment amounts.

> they feel like you're hiding something, it makes everything, everything that you've done become … you become skeptical of everything you've done.

Apologizing was identified as an effective risk-reduction technique.

In addition to apologizing, the participants explained other communication techniques. The OBGYNs stressed the importance of honesty and full-disclosure with their patients. Dr. Rockstar explained,

> I communicate – very open. If something goes wrong, I tell you what went wrong and why I thought it went wrong, um, and try to explain everything so that, at least, you know, people can... at least I can try to do my best to help people walk away from a situation, understanding what happened.

Dr. Bento also spoke about working with her patients to allow her patients to help them make the best decisions. She stressed the importance of carefully "counseling" her patients while also stressing "patient autonomy" in decision-making. Dr. Six explained the importance of transparency with patients:

> I tell everybody that of all these things that I do to people, bad things happen 1% of the time. The really *bad* things, like blood clots and transfusions, holes in bladders and rectums and stuff, we have to re-operate. That all happens 1 in 100, 1 in 200. I've done thousands of these things. So yes, I've had every problem known to man, so I tell every patient that.

Dr. One shared the most in-depth information about how she communicates with patients when she is behind schedule:

> I don't tell them the whole scenario, but they get my full time because the last person got my full time. If I don't have a pamphlet, I will draw them out information. I will call and get someone on the phone for them, I will get them a phone number because it's only fair. Because they might not have an Internet. They might not have a phone. It's just not fair for them if they don't have the resources the last patient did. I draw pictures a lot. The good part is to be able to speak Spanish. I think that that is very helpful.

The OBGYNs clearly employed communication as a risk-reduction technique with their patients. They had been taught through the "informal" or "hidden" curriculum that they needed to build rapport with their patients. They also believed that when unexpected outcomes occurred they should apologize to their patients.

The IMED physicians also discussed techniques similar to those used by the OBGYNs and how such methods limit their medical malpractice liability. Dr. Fields expressed the need to "connect and communicate" with patients. She said, "You have to listen. And that's where I think physicians go wrong because we don't have the time to listen, you know." Dr. Luke explained, "I'm very honest with them. I don't pull any punches when there's bad things going on. I tell them. And so I think that limits my risk." Dr. B said he does not worry a lot about medical malpractice, but followed that with an explanation that he does counsel his patients regarding their medications.

Dr. Luke, an IMED physician, detailed the power of rapport in avoiding a lawsuit:

> If patients like you, you can be the dumbest person in the world, but if you're, you know, give them a high-five when you walk in, talk about their kids or grandkids or whatever, and they like you, it doesn't matter. And you can be the best surgeon or best doctor in the world, but if you have no bedside manner, and you're curt with somebody or rude or, you know, mean or something like that…you make one little slip-up, you're, you're, immediate, you know, you're a[target].

He went on to say, "Bad doctors can coast through pretty good, if they're nice."

The participants explained several communication practices they use to avoid being sued, including apologizing, counseling, listening, being honest, and just being friendly.

Patient Management Skills

The participants identified their patient management skills, developed through experience, as a second medical malpractice risk-reduction technique. Participants discussed the importance of staying up-to-date with the medical standard of care as well as the need to stay within their defined medical scope. Dr. Bento, on OBGYN, said, "I try to keep up-to-date with everything so that way I do all the recommended, you know, whatever is recommended." Dr. Fields summarized this theme:

> If I practice within my scope of medicine…if I ask for help when I *know* I don't know the answer…and if I always do my best …. and I know when I'm [not] up-to-date on something that's changed…you take initiative to read about it. And as

long as I'm doing those things, it really is hard to be negligent to the point that [I'll] be successful sued.

The participants also talked about passing on certain procedures or patients in order to reduce their medical malpractice risk. Dr. Rockstar, an OBGYN, said she protects herself by trying less invasive procedures first; she is "very slow to do certain things like surgery." Dr. Bento, another OBGYN, discussed that she has learned to refer patients to specialists when their medical needs exceed her training, "So that was really hard for me to give it up because I was like I know I can take care of this, but it's not the right thing to do at this facility. And so I've learned to…let go." Dr. Bento recognized that while passing along patients could help protect her from lawsuits, it did impact her financially:

> Because I wouldn't be able to provide the best care for them. And so, because I think that way, I am protecting myself against malpractice as well, but it's just because it's not going to be the best care. I can't…we do have a physician who keeps everything and it's because of money. Because if you do keep those patients, you do get a lot more money for every visit that you see. And I just don't think it's the best care. But you have some people who are more money focused.

IMED physicians also talked about passing along patients to avoid a possible lawsuit. Dr. B referred to a patient who had a hip replacement. When the procedure went poorly, the patient sued the orthopedic doctor. Dr. B noted that the patient was non-compliant and unhealthy. He explained, "If I was the surgeon, it's one of those cases

where you just kind of walk away, but you're trying to… Patient has complaints, you want to fix it." Dr. Sabrina asked another doctor to take a patient simply because she had seen the patient in the past and knew that the patient disliked her on a personal level. She said,

> So when I got the call for that admission, I called another doctor and asked him to take it, saying that the family's not going to agree with me, or it's not going to be a good situation. He had a resident on with him at the time, and I gave the checkout to the resident, and the next day the resident came back and he goes 'Oh, that was a good idea. She does not like you.' Eh, what can you do?

Passing along patients or procedures was a malpractice-avoiding technique. Learning when and how to stay in scope, seek more information, and pass along patients or procedures was something the participants said came with time in practice; they learned it on the job.

Documentation Skills

The final risk-reduction theme that emerged from the participants was documentation skills. They expressed a need to document their interactions with patients in order to avoid a medical malpractice lawsuit, or if sued, to defend such a suit. Two of the less experienced OBGYNs explained that they have been taught to document due to possible lawsuits. Dr. Rockstar said, "When you're a resident and you're training, and in medical school too, you know documentation is everything. It's kind of pounded into you that you've *got* to document" [emphasis original]. She went on to say, "I don't even know how you come about this, but you do have a sense that people get sued. You better

do things correctly, don't screw things up…don't write something down in the chart that's ridiculous." She then tied her documentation skills to a potential lawsuit:

> Because if you're ever in court, you need to be able to defend and explain what you've done. You know, it may happen... just in OB, you know, they have 18 years to sue you, so it may be 10 years down the road, you can't even remember what happened. So all you have is your documentation. And so there's just a lot of talk about how do you document and... even amongst... talking to physicians who have been sued before, what their experience was and... and what they wish they had done differently.

Dr. Bento gave a similar explanation of how she documents patient encounters in order to defend a possible lawsuit:

> All of my documentation is electronic. Um, when I get to my assessment and plan, whenever I talk about risks, I document all the risk that I talk about. And then I put that the patient voiced understanding. Or if patient has a thickened lining on the sonogram and she's having post menopausal bleeding but she doesn't want to do a biopsy, I make sure I documented her risk of missing a cancer and you know I do make sure that I do document. I think documentation is really important because it's a he said/she said in court.

Notably, Dr. Rockstar and Dr. Bento attended the same residency program where their director overtly taught them to think about medical malpractice (see Medical Training and Experience section below). However, Dr. One, another OBGYN who trained in another program had a similar understanding. She explained, "Since we've entered

electronic medical records…if you don't document it, it didn't happen."

Dr. Six, an experienced OBGYN, said that there is no formal training about documentation during medical school or residency. He explained that he is currently on a committee at Regional Hospital to tell doctors when they use inappropriate words in a chart. For example, Dr. Six said, "One [doctor] wrote in the chart he did an 'inadvertent' – he was doing a hysterectomy and got a hole in the bladder. So he wrote, 'inadvertent cystectomy, repaired, no problem.' Inadvertent means careless in the dictionary." Dr. Six said the committee counseled the doctor that he should not that word in his charts. He explained,

> So when the residents in [Regional Hospital] today are going to have a lecture on pre-term delivery and they're going to have a lecture on forceps and they're going to have a lecture on Apgar scores, but they're not going to have a lecture on, you know…they might say to the side, 'Now, you guys don't write in the chart this or that.'... You sort of unfortunately learn those things the hard way.

No matter how charting education is delivered – either formally or informally – it seems that the OBGYNs have learned that documentation is a key to medical malpractice avoidance and defense.

One OBGYN and several IMED doctors also talked about good documentation and how it can be used to defend a claim. From the OBGYN participants, Dr. Obg was the only one who referenced his documentation as specifically helping him defend a claim. A patient has filed suit as well as a TMB complaint claiming that he failed to diagnose her cancer. He explained that the patient had never mentioned any problems,

not even by phone, until her office visit:

> Our office records uh … at that time everything was electronic medical records, so *any* phone call, *any anything* that interacted with the patient is documented. I mean, if there's any one nice thing about electronic medical records is your documentation is there.

Dr. Obg is confident that he will be able to defend this case due to his documentation.

Several IMED doctors have had similar experiences. Dr. Luke explained that Regional Hospital thought that documentation was important and that it was reviewed during his orientation. He also talked about how his mother's experience as a nurse with a medical malpractice law firm in Florida influenced his documentation practices:

> I do think I need to document things appropriately for the off chance that, you know, someone else looks at this chart, it needs to be fairly complete. I think, and this is from my mom… you can look at charts and records, you can always find something, you know, but you want to make sure that you're doing the major stuff, all the stuff, and the major stuff right.

Dr. Who said that when she received a Texas Medical Board (TMB) claim, she used her documentation:

> And, our documentation was good enough that even, like, without TMB asking, legal advised us that we should go ahead and provide all of the documentation that we had, because it also had some things in there about how the daughter was in New York the entire time the patient was in the hospital, and had all these different attempts at contacting the daughter, you know, documented, and what

the conversations were, or weren't, if we couldn't reach her.

The TMB complaint against Dr. Who was ultimately dismissed, which she attributes to her detailed documentation.

Dr. B, another IMED doctor, explained that he is "a better documenter than most people." In fact, another physician defended a medical malpractice claim using his documentation:

> I had really good notes that really outlined the risk of complication. And so, the orthopedist's notes probably weren't very good. And the patient had a great case until they called my notes. And the patient has since left my practice because he was frustrated with my notes. My notes were really good…I think [the patient] was very frustrated with my records because he did comment that the surgeon did get off.

Thus, in two instances, IMED participants used their documentation to avoid or defend against legal action.

No matter their level of medical malpractice concern, the participants used certain risk-reduction techniques. These techniques can be grouped into communication skills, patient management skills, and documentation skills.

Before concluding this section, it is important to note that when the participants talked about documentation, many of them talked extensively about their move to Electronic Medical Records (EMRs). As Dr. B pointed out, Medicare and Medicaid payments now tied to the transition to and "meaningful use of" EMRs. Therefore, most practices have transitioned to EMRs (Centers for Medicare and Medicaid Services,

2015). While some participants recognized the positive aspect of having many records accessible in one place, most participants had negative comments about EMRs.

Two OBGYNs pointed out specific problems with EMRs. Dr. One voiced concerns regarding both in finding and recording information in a timely manner:

> And a lot of times when you look back and you're reviewing your own case or someone else's case you can't find things documented. A lot of times, the way that happens is because when things happen they happen so quickly you can't sit down and find ... I mean you have to put it into a computer, you can't write it down. So, if you don't have a computer, you write it down and you can back time it, but when you're backlogging it still comes out as the time you wrote it not the time it happened. You can type it in, but then you look like you're trying to you know... but you can't sit down in the computer when you're trying to save someone's life.

Dr. Rockstar, an OBGYN at Regional Hospital, talked about how difficult the EMRs are to navigate:

> The EMRs, this is my opinion, were thrown on the market because they had to be there, and so they're robust and that they can do a lot, but it is so un-navigable and so difficult, that you're trying... you don't even know how to do anything, and you can't figure it out. It's like someone threw up on the screen, and there's so many things I could choose…I wish Apple had made the EMRs so that it's actually user-friendly.

She has become so frustrated with the system that she has started to simply click through

the screens. She admits, “And I’m not even looking at it…I’m just clicking the buttons because you have to freaking click the buttons.”

The IMED physicians had similar complaints. Like Dr. Rockstar, Dr. B found the interface difficult to navigate:

> I would tell you I was a better physician before EMRs than I am after EMRs… and it’s not that I’m not a good physician. It’s the organization of an EMR and the time it takes to find things, um, because what I hate doing is sitting there and telling the patient, ‘Wait just a minute let me see how many clicks I can get to find the information you want.’

Dr. Luke echoed these sentiments. He said his notes were more thorough before EMRs because he was able to input the information in the format and order that he preferred. He said with EMRs, “to get all this data and type it in the way a lot of these places want it, it makes it a little bit harder.” Dr. Luke then explained,

> And so what happens, I think, is they lose some of that detail. And it’s not so much that you lose it completely, it’s in there somewhere, but it’s not all outlined in that note just like that…down the line.

Dr. Luke went on to explain that the EMRs have added time to his patient encounters and that he is less efficient. He also explained that it is difficult to find information in the EMRS. “So now when I read somebody else’s note, another physician’s note, I have a hard time necessarily telling what’s going on either because I’ve got to dig through all this stuff.” Despite the difficulties of transitioning to EMRs, Dr. Luke did say, “There are some good things about it, but, uh, maybe it’s just change, and no one likes change.”

All of the participants in this study started their medical careers with paper charts and have been practicing during the transition to EMRs, so perhaps Dr. Luke is correct.

Coping Mechanisms

Feeling Insulated

One coping mechanism identified by the participants was a feeling of being insulated from medical malpractice. All of the Regional Hospital IMED participants said they were protected by Regional Hospital. When asked about medical malpractice, Dr. Washington replied, "I work in a kind of in a protected environment at [Regional Hospital]." Dr. Sabrina similarly said, "I don't, honestly pay much attention to it, because I'm covered here." Dr. Who also said, "It's been very helpful, actually, I mean, to not have to worry about that piece of it." And when Dr. Adams was asked about the cost of malpractice insurance, he replied, "I'm somewhat insulated from that here, because we don't have independent malpractice insurance coverage. It's provided through the in-house legal department."

Several of the IMED participants referred specifically to Regional Hospital's in-house legal counsel when expressing their feelings of being protected. Dr. Adams was glad to have access to the Regional Hospital in-house counsel in case of a lawsuit, "It actually makes me feel a little bit warmer and fuzzier to know that the people that would be representing me are employed by the same person I am." He went on to talk about what he has seen from Regional Hospital's in-house counsel versus what he has heard from colleagues in other practices:

They'll sit down and go through it with you, and because they're here on-site all

> the time. Like you always have continuous access to the resources, and interview prep... they will fight it almost all the time… that's to some extent not the case of people who have malpractice insurance coverage outside.

Dr. Washington also stated, "Our in-house counsel is very aggressive and they, they tend to negotiate early on and a lot."

Dr. Washington had firsthand knowledge about Regional Hospital's counsel since he was sued early in his career. In recounting his lawsuit experience, Dr. Washington talked about the in-house counsel "So they try to protect us as much as they can…they were able to, you know, get me, get my name removed from the list of defendants and, uh, they settled. I never had to go to court." He also explained,

> We have a good relationship with our in-house counsel. They are all very good… we do have a lot of access to them. They're very down to Earth people and they're on our side, and, and it's comforting knowing that they're here.

Dr. Washington clearly appreciated how the in-house counsel handled his lawsuit.

There was also recognition that Regional Hospital was able to provide this insulation due to its size. Dr. Luke explained that Regional Hospital was better than the smaller, private practice he came from at identifying mistakes and taking actions to rectify them. Dr. Washington summarized, "When you're in a big program, you can afford to have in-house counsel and, and better malpractice policies and things like that. Um, it doesn't completely protect you, but it's helpful, I think."

The IMED participants employed by Regional Hospital all felt protected from medical malpractice and many specifically relied upon the in-house counsel. Notably,

the OBGYNs who were also employed at Regional Hospital did mention that they had in-house counsel, but none mentioned a feeling of insulation. Location could contribute to this divergence because most of the Regional Hospital IMED participants are physically located in the same building as the in-house counsel while the Regional Hospital OBGYN participants were in another city.

Admitting Limitations

The second coping mechanism that the participants identified was accepting their limitations. They openly admitted that they could not control everything; they are only human. For the OBGYN group, three participants talked about this theme. Dr. Obg explained, "I know that with every patient, I try to do the best care I can, but I'm human, and I may make a mistake, and it may harm somebody sometime." Dr. One similarly said, "No one's perfect, a surgeon can make mistakes. If I make a mistake or if something goes wrong in an operating room…you have to tell someone. You can't lie about that. Everyone's human." And Dr. Six summarized what he tells his patients:

> I've done thousands of these things. So yes, I've had every problem known to man, so I tell every patient that. I'm no God, no hero, no Superman. And if you go to another doctor's office and they tell you they don't have problems, they're either very young or they're a liar, and either way you need to leave.

The IMED participants had similar comments. Several IMED physicians talked about the need to be perfect. Dr. B explained that people would like their doctors to be "perfectionist." He went on to clarify, "And unfortunately we're all people and none of us are perfectionists and, uh, or I mean we're all perfectionists in, in what we want to do,

but we're, we're not perfect." Dr. Sabrina explained,

> You can't control how someone reacts. I don't think that I appreciated that in the beginning. I think I wanted to make everything perfect, and I think that I wanted everyone to be happy, and I wanted everyone to like me. Now I can only adjust to what I think the patient or the family needs. And either it's effective, or it's not effective. But I can't control it.

Dr. Luke also explained that "we're all wrong at some point in time…we're not perfect."

Several participants gave more detailed information. For instance, Dr. Who explained:

> I will probably be sued, just because the odds are that it's going to happen. That I'm not a perfect person…I'm not a perfect provider, um, there's going to be something that doesn't go right with someone, and no matter how good of a communicator or bedside…uh…you know, patient care I may provide, there's gonna be someone who just can't get over the fact that something went wrong with their loved one. And, and I'm not gonna be able to help it.

Later, Dr. Who elaborated,

> I want to make good decisions, I want to take good care of patients, I want to stay up on my medical knowledge, but at the same time, I can only control what I can control, and beyond that, it…in the end, it's just a life situation…

The participants understood that there are some things that are out of their control, and accepting that has helped them cope with the risk of a medical malpractice lawsuit.

For research question one, the participants were asked to explain how they make

sense of medical malpractice and their coping strategies. The four themes reviewed above included, first, their legal knowledge. As explained above, they had two types of legal knowledge: tort reform and legal system characteristics. The second emergent theme was participants' personal risk assessment, which varied by specialty. Third, the participants detailed three risk-reduction techniques – communication skills, patient management skills, and documentation skills. And finally, the participants identified coping mechanisms. In the following section, the participants explain what resources influenced their articulated understanding.

CHAPTER IV

MEDICAL MALPRACTICE INFORMATION FOR PHYSICIANS

I think what we hear about is so skewed one way or the other. That's the issue. What I hear about on the news or whatever, it's, it's usually either some terrible tragic thing happens like … they throw away a transplanted kidney.

– Doctor Luke

In this chapter, the findings for research question two are reviewed. This question asked participants to identify sources that influenced their medical malpractice knowledge. The participants cited four primary sources as influences on their medical malpractice understanding: 1) memorable personal experiences, 2) medical training and experience, 3) information from external organizations, 4) information from unspecified sources.

These findings are ordered from the most influential to the least based on the intensity and the frequency with which the participants expressed the themes. To order the themes, I relied on Owen's (1984) three criteria for identifying themes: recurrence, repetition, and forcefulness. Recurrence occurs when the same meaning is identified at least twice, regardless of the words used. Repetition involves words, phrases, or even sentences being repeated. Forcefulness accounts for how participants emphasize certain points through their tone, volume, or by using pauses. In this study, personal experiences are listed first because each experience revealed by a participant illustrated an event that

had greatly impacted him or her. The participants' tone changed when they talked about their personal experiences and they lingered on salient points. These experiences obviously influenced their understanding of medical malpractice. The next category – medical training and experience – is listed second because of the frequency with which participants identified shared medical training and consistent experiences. For instance, the eight participants employed by Regional Hospital spoke specifically about their in-house legal counsel as a source of medical malpractice information.

Information from external organizations is listed third because most participants cited to specific sources. However, with the exception of Dr. Stork and Dr. B, who both relied on information from the Texas Medical Association regarding medical malpractice, the other participants' citations were perfunctory. They referred vaguely to emails from national organizations. The OBGYNs did cite to practice-specific publications, but otherwise, the citations were an obligatory mention of one or more organizations. Finally, information from unspecified sources is listed last. Almost all participants strongly asserted some statistic regarding medical malpractice, but when asked for the source, the answers were inconsistent. Some cited the media, while others admitted that they did not know the source, and still others cited mere "common knowledge." The four themes are discussed below.

Memorable Personal Experiences

First, participants relayed personal experiences that influenced their medical malpractice understanding. The three main experiences cited by the participants were prior legal claims, experiences while patients, and discussions (or lack thereof) with

close family members. Each is reviewed in turn.

The most poignant experiences were prior lawsuits or Texas Medical Board (TMB) complaints filed against the doctors themselves. As indicated in Appendix B, the three more experienced OBGYNs and one IMED doctor had been sued for medical malpractice. Two doctors – one of the experienced OBGYNs and one IMED doctor – had also received TMB complaints. All five doctors discussed these legal complaints during our interviews; the three experienced OBGYNs then went on to explain that they now serve as legal experts.

All three previously sued OBGYNs discussed how being sued occupied their thoughts, to the point of making them paranoid. Dr. Six said following his last lawsuit, he would have the following thoughts, "you'll hear people talking in the hall and you're thinking, 'I wonder if they're talking about me?'" When recounting his lawsuit experiences, Dr. Stork said, "It's hard…You try to blow it off, but you think of it all the time. And you try not to take it personally." Dr. Obg had a case go all the way through trial, where he ultimately won. Even so, he said, "it was probably one of the worse experiences in my life – going to court." He explained his thoughts and that he became very ill during the trial process,

> Of course ... back then, you know, I'd been in practice five years. My…that was my very first experience with the legal system. And, and, uh, you're paranoid about every little accusation and, and thing, and, and you think, 'How is a jury that never practices medicine going to understand, uh, the significance or lack of significance of this issue that they're ...trying to make a big deal out of.' And,

> and so I'm just, you know, I'm a type A personality. I obsessed over every single issue of it, and, uh, but I didn't, I had no idea that my pains had anything to do with that trial. I thought I, I thought I had stomach cancer. I thought I had pancreatic cancer. It had to be something, and, you know, I had MRIs and I had upper GIs, and I tried ten different medications.

Clearly, these doctors were negatively affected by these experiences; however, all three are acting in expert roles now and have evolved impressions of the legal system.

Dr. Six now reviews malpractice cases for his employer, Regional Hospital. He says his revised understanding of the legal process came when he had a patient who had previously sued him for medical malpractice come back as a pregnant patient. He explained,

> After you've been sued once or twice, e-especially after that lady came back to my office, it all kind of crystallized to me, you know, it's like, okay, they don't even dislike me. (laughing) This is about – just money. They're not even mad. And then it, it helped me.

Both Dr. Stork and Dr. Obg now have a better understanding of the legal world and are both working as hired expert witnesses. Dr. Obg has reviewed "at least 500 medical malpractice cases" and has "done at least 40 depositions, been to trial 15 times." He said, "I know the ins and outs of the medical malpractice world." Dr. Stork, shared the following thoughts regarding his most recent expert witness request,

> I would go out of my way to support a physician because I think it is a judgmental thing, but I could not support it. And they were looking for someone

> that could support it and I just said there's just no way that I can support it. And that case, I'm sure, settled out of court and it should have settled out of court because now … I reviewed it and I said I can't support this case; I think that this was negligent.

Obviously, the three sued OBGYNs have different thoughts about the legal system as time has passed. Dr. Stork and Dr. Obg also reviewed their thoughts regarding settling cases based on their prior legal experiences.

Dr. Stork was against settling in general, but said that he had settled a case because the plaintiff worked for the judge in the case. He explained, "It was purely a business decision." Dr. Obg also noted that settlement could be the path of least resistance:

> I'll tell you this, the one case I had where I went to trial, you know, I was two weeks out of my office ... Lost revenue from that two weeks, stress, uh, all that sort of stuff that goes on with that. If I were to be sued again, and I thought I had any liability whatsoever, I would say, 'Settle this. I don't want to go to court. I don't want to mess with it.' That's why I buy my insurance. And that's probably a bad attitude. It would encourage, you know, settlement of a case that otherwise might not…

The two IMED doctors with previous legal actions also detailed their situations. Dr. Washington was named in a lawsuit after practicing at Regional Hospital for only one month. Even though his name was removed from the lawsuit, he told me,

> I thought, 'If this is how I'm going to start my career, then, you know, I don't

know if this is for me.' So I was starting out my career with a bad taste in my mouth, basically. Almost made me, almost made me not want to be a doctor.

Dr. Who was less affected by her TMB complaint. She explained that it was time-consuming and came during the winter holidays, which made it more difficult to deal with. However, her encounter with the legal system was less stress-inducing than Dr. Washington's.[37] Although the participants who had some interaction with the legal system demonstrated various levels of stress, they all mentioned these instances as influences on their medical malpractice understanding.

Three participants discussed their experiences as patients as influences on their medical malpractice views. All three went as far as indicating that they, or a family member, considered filing a medical malpractice lawsuit.

Dr. Sabrina, an IMED doctor, had the most extensive patient experience. She was hospitalized for three months. Just a few years later, a relative was hospitalized for six months for a similar medical condition. As mentioned above, Dr. Sabrina saw numerous errors as a patient, but she found it much more difficult to see mistakes in her relative's medical care: "I would much rather deal with the physical pain, and the struggle, and the nausea ... than watch her do it. Or watch the stupid mistakes being made on her."

Dr. Sabrina was well versed in her relative's condition, as it was similar to her own. At one point, she saw that her relative was in need of a surgical evaluation, but the internal medicine doctor refused. Dr. Sabrina noted a competitive dynamic between the

[37] Dr. Who noted later in the interview that she relied heavily on her religious faith to cope with medical malpractices; this reliance could possibly explain why she was less stressed than Dr. Washington.

two groups, “[Internal] medicine always thinks they’re right, surgery always thinks they’re right ... they don’t play well together, generally.” Finally, a surgeon came and Dr. Sabrina’s relative was rushed to surgery. Due to the delay, the surgery took longer than it should have and was more extensive. Dr. Sabrina said, “That time, I threatened malpractice.” She never pursued any legal action, but she did insist that the hospital have a morbidity and mortality (M&M) meeting stating, “I want the entire ICU to learn from this."

Dr. Fields, an IMED doctor, recounted three specific situations of possible Texas medical malpractice claims in her family. First, she had an aunt with a botched hip replacement. Her aunt’s surgeon continually reported to other doctors that she was “fine,” but one emergency room doctor urged her to seek another opinion. When her aunt finally found another surgeon willing to redo her surgery, Dr. Fields recounted, “He said that the prosthesis was put in completely backwards. It was not even in place. So he said, ‘I don’t even know how you moved your leg forward.’”

Dr. Fields had two other suit-worthy circumstances. Her sister-in-law was given an inappropriate medication by her doctor. In that instance, the doctor prescribed Clomid, a common fertility drug. The doctor indicated that it was to help regulate her sister-in-law’s menstrual cycle and would not cause pregnancy. Her sister-in-law not only became pregnant but had an ectopic pregnancy, a common side effect. She not only had to undergo a painful surgery, but lost one of her fallopian tubes in the process.

Dr. Fields’ husband’s grandmother suffered the final medical injury cited by Dr. Fields. His grandmother had a full knee replacement. But when she experienced pain

during physical therapy, an x-ray revealed that the doctor had not actually put in a new knee. Dr. Fields recounts, "There was no new hardware in there. How that happens is mind-boggling. And so they had to get an attorney, request the records. *No* hospital records of this, of the surgery actually even taking place." Upon investigation, the family discovered that the treating doctor had packed up and left town after treating many elderly patients and being paid by Medicare. Dr. Fields explained how she felt following these three situations:

> And I always tell, you know…I am not a suit-happy person. I'm a physician. I don't think…I think that most people that do it are angry, but I think you have a real thing going on here that is really not right, you know.

Finally, Dr. One, an OBGYN, also considered filing a lawsuit due to a bad situation with one of her own doctors. She said, "…I feel like as a patient…I've only been close to like wanting to sue one doctor." When asked to elaborate, she explained,

> Had he actually counseled me more properly and had he said to me he was sorry and had he not lied to my face and said things that were not true like all these things, I would have liked him more, and had I liked him more, I probably wouldn't have been so angry. And as a patient, if you're not angry you're not going to want to sue your doctor because you know that they're human. But if they're trying to act godly…you're going to get really pissed off and think that they're an asshole.

This specific encounter has led Dr. One to make a concerted effort to be friendlier with her patients. She has been criticized by others for her approach, "I think some of my

colleagues don't like me because they're like, 'You don't wear your white coat. You act too friendly with the patients. You sit on the bed at the bedside. You're too friendly with them.'" However, Dr. One has continued with her chosen style:

> For me, that's part of what I feel like just makes it better and easier and some people don't agree with that style, but for me, that's what I think and I hope makes me a better doctor. But also, in the future, could keep me out of a bad legal situation because people like me.

Dr. One and the two IMED doctors used these patient experiences to shape their medical malpractice understanding.

In addition to prior legal dealings and experiences as patients, two IMED doctors mentioned having parents in the medical profession as an influence on their medical malpractice understating. Dr. Washington's father is also an IMED doctor, who has been in private practice in Texas for 50 years. When Dr. Washington was sued for malpractice early in his career, he said, "I was in shock. Um, like I said, my dad had never been sued in 50 years and here I am starting my career and one month in ... and I'm getting sued." When asked later about medical malpractice insurance coverage, Dr. Washington said does not think about it much, but,

> I worry about my dad sometimes…Um, but he's exposed. I mean, if somebody decides they want to sue him, um, then he has to ... You know, he has malpractice insurance, but he's got to spend all that time, and um, all that extra money, to do whatever it takes to defend himself. And, you know, he's 77-years-old, so, um, that would put a lot of stress on him, I think, to go through that at

this age after such an illustrious career, you know. So it's something I worry about for him sometimes.

When asked if he has talked to his father about medical malpractice, Dr. Washington simply said, "I haven't. Um, he's never really mentioned to me." These comments seem to solidify Dr. Washington's decision to practice medicine in the insulated environment provided my Regional Hospital.

And finally, Dr. Luke talked about his mother's prior job as a nurse reviewing medical malpractice cases at a Florida law firm. She was responsible for review plaintiff's medical records and determining if the doctor made an error. He went on to say the cases she told him about led him to the following conclusions:

> I'd hear about some of these cases, and, you know, I've always known, you know, it's, it's obvious, I mean, there's bad doctors out there. And bad doctors need to be, you know, questioned. And if they make a mistake, if I make a mistake, anybody makes a mistake, whether good or bad, we cannot … if we made a mistake and we knew we shouldn't have made the mistake, we did something wrong, then we should be held accountable for that. In some form or fashion.

Dr. Luke's discussions with his mother helped him form his opinions regarding medical malpractice.

As expected, these personal experiences such as prior legal claims, patient experiences, and conversations with family members greatly influenced the participants' medical malpractice understanding.

Medical Training and Experience

All participants mentioned some medical training or experience as a source for the medical malpractice understanding. Not surprisingly, several of the younger participants mentioned learning about medical malpractice in their training during medical school or residency.

From the OBGYN group, Dr. One recalled, "We've had speakers come in like throughout medical school and residency and some, I can't remember who they were, like attorneys or businessmen who were kind of dealing with like, you know, malpractice stuff." Dr. One also recalled specific information disseminated during medical school: "When I was in medical school, they said that like OB's were the highest rates of physicians that got sued … or physicians with the highest rate of being sued."

The two other young OBGYN participants – Dr. Bento and Dr. Rockstar – attended the same residency program. According to Dr. Bento, "when I was in residency it was very malpractice oriented." She explained,

> So, in residency I thought it [malpractice] was huge. Everything we did, everything we were taught. I remember Dr. [Resident] was always stressing, um, you need to get this because this is what could happen. You could be sued later. For every vacuumed-assisted delivery, you always need to get a cord gas[38] because that could save your ass in court. For every, you know, anything, any

[38] The "cord gas" means that shortly after birth the medical team can take a sample from the newborn's umbilical cord in order to ascertain the baby's health at the time of delivery (Thorp & Rushing, 1999).

> Apgars that are under this, you need to get a cord gas. So everything he was teaching us, it was in practice, it was to protect yourself.

Dr. Rockstar had similar sentiments about the residency program and a possible explanation for Dr. Resident's teaching style. She said, "[Dr. Resident] actually had been, uh, practicing in Florida. And Florida, by his description, is a *terrible* state for malpractice. And so the way he thought about everything was completely, completely, um, colored by his practice in Florida." Dr. Rockstar recalled details that were similar to the those articulated by Dr. Bento. Dr. Rockstar said,

> And so he taught us everything. He taught us, never cut a baby when you go on a C-section. Not that you ever would, but he's like, 'The last thing you want to do when you're doing a C-section is cut the baby's face.' And then, you know, he would, um, talk about how you should always get cord gases so that you can prove that your baby was... you know what I mean? So then there's the debate. Should you get cord gases, should you not? But he always felt like we should. He said everybody in Florida gets cord gases. You know. Which is just one more expense and kind of unnecessary...

Clearly, both Dr. Bento and Dr. Rockstar were influenced by Dr. Resident's teaching style with regard to medical malpractice. In fact, Dr. Bento later explained, "I've noticed in the real world that it's not… everybody's not out to get you. But that's how we were…that's what we were taught."

In the IMED group, the male participants talked about medical school or residency, but they had less specific recollections. Dr. Luke said,

> That's part of what they taught during medical school and when we did our clinical stuff, intro stuff, before we went to clinical the part. And then, at the end of, um at the end of med school, our last few weeks in school, they brought everybody back…some of it was, you know, ethics stuff, medical/legal stuff, and you know, and that gets mentioned a lot, you know.

He went on to say that he learned more about medical malpractice later in his training, but "probably more in residency than fellowship." Dr. Adams had similar thoughts. He said,

> I probably had some exposure to it [medical malpractice] during medical school, but I may not have been paying as much attention at that point as I am ... as I was in residency, and afterwards. And I don't think that was a big ... it may be more of a focus now than it was when I was in school, I don't know.

Dr. Adams also received medical malpractice information during his residency. He said, "I would say in residency that there were some staff, that for whatever reason, would mention [medical malpractice] more often than others." Dr. Adams surmised that a focus on medical malpractice might have something to do with whether or not a teaching clinician "had previously been sued and the other ones hadn't."

Three participants stated that medical school or residency did not provide medical malpractice information. Dr. Six, an OBGYN, explained:

> These things aren't taught in medical school. You know, we're not taught how to be businessmen, let alone how to defend – you know, even how to make a living, let alone then – to then deal with the malpractice aspect of it.

Dr. Washington, an IMED doctor, echoed this sentiment. He said, "Medical school didn't prepare us…I hear a lot of people say that, uh, in medicine is that they wish they had learned a little bit more about jurisprudence and a little bit more about the business side of medicine." Finally, Dr. B, an IMED physician, said, "I know in my residency program, they did not really train me how to code, how to bill, um, malpractice, it really wasn't part of our training program."

While all participants mentioned medical school and residency, only some participants cited to other experiential resources for medical malpractice information, such as talking to other physicians, consulting with in-house counsel, and practicing medicine.

Two OBGYNs mentioned learning about medical malpractice by talking to other doctors. Dr. One said she knew several physicians who have been sued for medical malpractice. She has talked about such lawsuits with fellow residents as well as "people from medical school that are different places now." As for learning about incidents that can lead to malpractice, Dr. One cited to formal meetings at her hospital:

> One of the biggest things we have in medicine is M &M, which is morbidity and mortality; it's like a conference they do about once every two weeks or once every four weeks in every academic institution and private institutions too. And that's where residents and faculty get up and talk about near misses or things that have gone wrong.

When Dr. Rockstar talked about learning about medical malpractice from other doctors, she focused on the need for appropriate documentation, "And so there's just a lot of talk

about how do you document and... even amongst... talking to physicians who have been sued before, what their experience was and how to... and what they wish they had done differently." She also recalled what doctors said about being sued for medical malpractice, "And the folks that I have talked to, even now in practice, who have gone through a suit, say it's one of the most horrific experiences to ever go through."

Five IMED participants cited discussions with other doctors as a source of medical malpractice information. Dr. Luke simply said that he had learned from "word of mouth" and cited to "other physicians." Similarly, Dr. Washington said he had heard about lawsuits "secondhand" from colleagues. He said most of this information comes from "my colleagues that are in emergency medicine. That tends to be more of a litigious population, I guess."

Dr. Adams said that he had heard "personal stories" from other doctors who had been sued for medical malpractice. He explained, "I've talked to quite a few people that have been involved around here [Regional Hospital] in those [lawsuits] just because of the way the system is set up." He explained the system as one where the patient "went back and sue everybody involved" in his or her care. Therefore, Dr. Adams said, "Almost all the lawsuits I know about people around here are usually because they're just this big ... a whole bunch of people. All ... everybody that's involved in the case gets sued."

Dr. Sabrina and Dr. Who were more specific with their comments. Dr. Sabrina said that doctors in her group talk about medical malpractice. She admitted, "You have to be fairly close to a physician, for them to admit to you that they've got a case against

them. That's not something that we publicize." Dr. Who also said that she talked with fellow physicians about medical errors that could underlie a medical malpractice lawsuit,

> Yeah, it comes up in conversation and, um, just here and there, with physicians about different situations, like, well, yes, I see why I made that decision, I would make sure that I document *this*, you know – we bounce things off of each other, um, about why we did or didn't do something.

The eight participants that were employed by Regional Hospital specifically mentioned their in-house counsel as a source for medical malpractice information. Dr. Rockstar and Dr. Six, both OBGYNs, cited to their in-house counsel as sources of information for malpractice. Dr. Luke, an IMED doctor, said that he met the in-house counsel during orientation and "they cover[ed] our malpractice." Dr. Fields said that she reads the messages "from the attorneys for the hospital." Dr. Who said that she attended lectures by the legal department, although she admits, "I've probably heard more of because I, I have historically been working with the residents." Dr. Sabrina also cited the in-house "risk lectures" for the statistics she recalled.

Two IMED doctors recalled more information from the Regional Hospital in-house lawyers. Dr. Adams mentioned that he had learned about malpractice issues from "classes from legal." He went on to give the following details:

> We've had a few talks from people in our legal department before, both in residency and as staff. But they – I mean, they have talked about a few instances, but they more talk in generalities in how things work, than specific instances. Of course, they do say, this is what you know ... they have some recommendations

about…these are things to avoid, these are things you know…that type of deal.

Dr. Washington also recalled meeting with the in-house legal department and the specific information they gave him:

> I remember what they told us when we first met them as residents. They came and talked to us. But I think it's in the 95 to 98 percent that don't go all the way to court. They're usually settled beforehand. And they are also very aggressive in that they try to make Regional Hospital named as the defendant and not an individual physician. So they try to protect us as much as they can.

As indicated above, both of these physicians, as well as many others, indicated that they were insulated from lawsuits due to their in-house counsel.

Finally, four participants – two OBGYNs and two IMED physicians – said practicing medicine influenced their medical malpractice understanding. When asked for any additional sources, Dr. One, an OBGYN, said "I would say probably just personal experience as being a doctor."

The other three doctors all mentioned not only their medical practice, but specifically that mentioned the "school of hard knocks." Dr. Six, an OBGYN, said, "I mean, you've got to pick this up through the school of hard knocks." Dr. B, an IMED doctor, explained, "I guess I learned from the school of hard knocks." And finally, Dr. Washington commented, "So we see a lot of patients here … a high volume, and, um, a lot of them, um ... So it's just through basically experience. Just the school of hard knocks."

Although the participants disagreed on exactly what they learned (or failed to

learn) in medical school and residency, they all mentioned these programs when asked for sources of medical malpractice information. Several participants cited to other doctors as sources for medical malpractice information. The Regional Hospital employed physicians also looked to their in-house lawyers. And finally, four participants mentioned medical practice as a source of medical malpractice knowledge.

Information from External Organizations

Most participants cited to medical resources, such as medical journals, for their medical malpractice information. Three OBGYNs mentioned receiving information from the American Medical Association (AMA). Dr. Obg said, "the American Medical Association is constantly sending out questionnaires to us…Sometimes I'll respond, sometimes I don't, but then they'll send out at, at some point, what their survey showed. So, I see all kinds of stuff like that." Dr. Bento also mentioned receiving emails from the AMA. Dr. Rockstar mentioned attending an AMA meeting to receive medical malpractice information. She said, "Yeah, an American Medical Association Conference, my senior year. And I went to a lecture on how to decrease, um, your own, um, rate of being sued and how to document appropriately."

Participants also mentioned the Texas Medical Association (TMA) and its publication, Texas Medicine. Three OBGYNs specifically talked about the TMA. Dr. Stork, an OBGYN, talked extensively about the TMA He explained that the TMA was active in getting medical malpractice tort reform passed in Texas. He said, "TMA has been very aggressive… TMA's just very proactive to get the ball rolling and they have all the right contacts I guess through all of their…political action committees and

everything else." He went on to explain why he puts his trust in the TMA organization:

> Their mission statement is truly … the Texas Medical Association has the mission to promote medicine, not, not just the business of medicine, but you know, to make sure patients' interests are protected as well. And so just, just the fact that they don't have any other ulterior motive except to promote, you know, it's not uh, it's not a third party. This, the TMA is, us. You know, it's not somebody else, you know, an outside third party.

Dr. Stork also detailed how he uses the information disseminated by the TMA. He had a copy of the magazine on his desk that he said he "glances" at each month. He also mentioned reviewing the electronic version. The TMA "hot issues" email was also a source of information for Dr. Stork. He explained, "They'll canvas newspapers across the state to say, you know, opinion pages, this is going on…and I always glance at titles. I may not read everything, but there's always going to be something."

Dr. Rockstar also mentioned the TMA. She said, "I went to a TMA meeting…and that's probably where I learned a lot of this, maybe." She also cited to information from the TMA, but noted that she no longer receives all of the information because she failed to renew her TMA membership.

The final OBGYN had a negative opinion of the TMA. Dr. Six said, "Texas Medicine is more like People magazine." He went on to say, "If I had an article in Texas Medicine, I wouldn't really tell anybody….I mean, it's not anything to be proud of...it's not a peer-reviewed journal; it's more publicity."

Two IMED doctors mentioned the TMA. Dr. B said, "I would probably tell you

that the TMA, Texas Medical Association is probably my biggest source on malpractice." He said that he reviewed emails from TMA as well as the Texas Medicine Magazine's information regarding doctors who have lost their licenses because they "have been found to be doing been doing things that may be inappropriate."

Dr. Luke notes that the TMA is a powerful resource for Texas doctors:

> I don't have anything to compare to other states, but I know that the TMA seems to, you know, be fairly active in protecting physicians in the way they do things, you know, we're a member of the TMA, and so I get, you know, emails and stuff like that from them.

He went on to say that he reviewed the TMA emails for malpractice information. He said, "If something catches my eye, then I might, you know, click on the "read more" option."

In addition to the AMA and TMA, participants cited other medical organizations. Four participants discussed the Texas Medical Board (TMB). Dr. Obg, on OBGYN, said, "Most of what I hear is…comes from either the, the board, they send out newsletters all the time."

Dr. Washington, an IMED doctor, said he also reviews the TMB emails where they "publicly list all the doctors in Texas that have been...brought before the board and what their punishment is and what their crime was." He even recalled the basic content covered in the emails:

> Most of the ones that I see are for people that are trying to run pain clinics without the proper licensing or, uh, they're having improper relationships with

> patients, that kind of thing. But occasionally you'll see a doctor that, um, was felt to have practiced outside of his scope or practiced under the influence of alcohol or drugs or something like that. But not a lot of, um, not a lot of doctors that are, uh, just doing their job and doing it in good faith and a patient complained to the board and then their license was revoked or suspended.

Dr. Six, an OBGYN, also mentioned such complaints. He explained that after tort reform, the TMB received more medical malpractice claims and that they accept complaints for "more minor things:"[39]

> We have now just a *huge* number of patient complaints, and all patient complaints to the [TMB] have to be investigated, and so that process, in my opinion, has turned out to be 'guilty until proven innocent'…I mean, you know, somebody reports that, uh, you were drinking on the job, they could smell the alcohol. Well, they'll chase that down to no end just to find out after months and this, that, and the other that that simply wasn't true. And there's nobody who's going to say they're sorry or anything and that you had to get an attorney and you took all this time out and by the way, the lady's changed her mind, she decided maybe you weren't that doctor.

Dr. Obg, another OBGYN, echoed Dr. Six's comments. He said "The Texas Medical Board is a zoo." He went on to comment:

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[39] Dr. Six implied that the TMB and legislature struck a deal that the TMB would have the latitude to investigate more minor infractions. Stewart, Love, Rocheleau, and Sirinek (2012) did find that following the passage of tort reform measures in Texas, the TMB disclosed that "complaints against physicians increased 13%; investigations opened increased 33%, disciplinary actions increased 96%, license revocations or surrenders increased 47%, and financial penalties increased 367%" (p. 568). However, it is unclear whether these increases were intended or unintended consequences of tort reform.

> I've reviewed several cases ... for physicians ... and the claim was, you know, to the board, and so I've been down that road also. And to my astonishment – just astonishment, if there's a complaint, there's a fine…and the length of time it takes for them is ridiculous.

Other participants also mentioned interactions with the TMB (please see the information detailed above).

Three of the OBGYN participants mentioned specific OBGYN-related organizations and journals. All three mentioned the American Congress of Obstetricians and Gynecologists (ACOG). Dr. Obg and Dr. Bento mentioned receiving emails from ACOG. Dr. Bento also mentioned reviewing ACOG's publication, Obstetrics & Gynecology, also known as "The Green Journal" She said, "We read their practice bulletins of what we need to do and what's been, you know...the standard of care, right. And they give opinions, things like that." Dr. Rockstar also cited to this publication, "The Green Journal is like OBGYN articles that get approved to be in the journal. And then they're kind of in the annals of medical literature."

Dr. Bento and Dr. Rockstar also mentioned OBG Management. Dr. Bento mentioned the OBG Management emails. She said, "The OBG Management is really good at just quizzes. So, they'll send like a picture and say.... so I will usually click on that. I'm interested in that." Dr. Rockstar said,

> Well, I have read in OBGYN Management, they have a section in their magazine that comes... talking about cases that have occurred, malpractice cases and how they were... you know, what happened and then what the outcome. And I've read

quite a number of those, and those are always interesting.

These informational emails seem to resonate with these two OBGYN participants.

Three participants mentioned three additional organizational resources. First, Dr. Bento mentioned receiving information from Medscape (owned by WebMD). Such emails could have influenced her opinions regarding medical malpractice. Similarly, Dr. Fields, an IMED doctor, mentioned an outlying resource – Medical Economics. Finally, Dr. Stork explained that he receives information from his insurance company – Texas Medical Liability Trust (TMLT). He explained:

> They give you statistics. So TMLT will quarterly send out stuff in terms of how many cases were filed, uh, how many are active, how many are, um, you know, how many were settled, how many went to court, and out of those that went to court, how many were won, so they'll, they'll send you all their data.

He also posited that many physicians get indirect information from the insurance companies. He said, "I would say that the majority of physicians look at what their premium is, you know, and that's all they look at."

The participants cited to a variety of organizations for medical malpractice information. The most commonly cited organization for these Texas doctors was the Texas Medical Association (TMA). However, one participant discounted the TMA's influence claiming that it was meant for "publicity." The OBGYN participants had several more practice-specific publications to review. And only one physician cited an insurance company as a source for medical malpractice information.

Unspecified Sources

Although many participants were able to give me statistics about their medical malpractice risk, none were able to identify a specific source. In fact, all but one participant (Dr. Fields) mentioned information but they could not quite account for the source. This theme, "unspecified sources," includes the following citations by participants: statistics, media, journals and conferences generally, and just plain common knowledge.

Six participants mentioned some type of medical malpractice statistic but could not recall the source. The three OBGYN participants had very different estimates. Dr. Obg, an OBGYN, said,

> Well, if you look at national statistics, um ...The ... I can't ... I don't remember the, the exact numbers, but, you know, your average OBGYN physician is going to have five or six cases in a career ... At least. Um, and that's when you're doing everything you possibly can do right.

Like Dr. Obg, another OBGYN, Dr. Rockstar had a specific statistic in mind. She said, "I think the actual numbers I've been quoted is that the average OBGYN gets sued two times in their lifetime." When pressed for where the information came from, Dr. Rockstar said, "you know, I've never seen the data on that so I can't say it's true." Finally, Dr. Six said, "The average OBGYN doctor in the state of Texas is sued 8 times during their career."

Three IMED doctors also weighed in with similar information. Dr. Adams guessed that he will be sued "once every 8-10 years" throughout a 45-year career. He

went on to explain that he could not recall a source for the information; it was "just a thought." Dr. Sabrina explained, "I think we've learned that within a doctor's lifetime, you're going to be sued 2-3 times. On average." But when asked where she heard this information, she responded, "I think I always knew it was going to happen, because I have that statistic in my head. I don't know where that came from." Finally, Dr. Who explained her malpractice risk: "I feel like I've been told, by someone, that every physician will be sued at some point in their career. That's what it – that's what I've been told." Again, when asked if she could remember the person who told her the information, she could not.

Five participants talked about receiving medical malpractice information from the media. Dr. Stork was the only OBGYN that mentioned the media directly. He explained that medical malpractice insurance premiums increased before tort reform. He said,

> Well, you could see it throughout the media. It wasn't just the TMA. You could see it in the newspapers and on TV and you heard these huge … you know, the guy that spilled the McDonald's coffee in his lap and gets $3 million or whatever, so you could see what was going on, just the liability climate in general.

Although Dr. Stork was the only participant to mention large jury awards, Dr. Luke, an IMED doctor also mentioned that the news reports the "extreme" situations. He recalled a specific situation:

> I think what we hear about is so skewed one way or the other. That's the issue. What I hear about on the news or whatever, it's, it's usually either some terrible tragic thing happens like … they throw away a transplanted kidney. Like they did in Ohio, I think.

These were the only doctors that mentioned specific "news stories."

Participants cited other media sources. One doctor, Dr. Sabrina, an IMED doctor, mentioned receiving information from televisions shows, "like ER shows." While another IMED doctor, Dr. Washington mentioned "the media," generally, as an information source. And finally, Dr. B, an IMED doctor, said he watches Fox news.

Several physicians also identified conferences or journals, generally, as sources for medical malpractice information. Dr. One, on OBGYN, said she received information at various conferences and "in review courses even which have nothing to do with the legal system." Dr. Bento and Dr. Six, both OBGYNs, mentioned reviewing case summaries in journals, but did not identify the sources by name. And finally, Dr. Adams, an IMED doctor, explained that he read "magazines," but he was unimpressed with the medical malpractice content:

> I'll get a bunch of different magazines. Uh ... occasionally they'll be a story in there about malpractice or, um, something related to malpractice. And I'll usually glance at it, but I can't say that I've ever ... to the best of my recollection, I've never read one of those where I was like ... wow, that's a really good point. I really need to, you know, remember that. And, you know, it's all just ... I don't know. Most of the time it's just real ... I hate to say 'fru-fru,' but it's real kind

> of… Very general, kind of obvious stuff. Like, 'if something goes wrong, tell the patient,' you know? Um ... 'always consult your' ... you know. I haven't read one yet that I was like, wow, that's … that's good stuff.

Dr. Adams thought most information he received from these magazines were merely "common knowledge."

Other participants also explained that their understanding of medical malpractice was common knowledge. Dr. Stork explained that "We all know what's going on." Dr. Rockstar (an OBGYN) and Dr. B (an IMED doctor) both cited to the ER and CAT scan relationship. Dr. Rockstar called it a common "joke:" "If you walk into the ER, you go to the CAT scanner and then you get checked in. You know, there's that joke." She goes on to explain what she calls common knowledge among doctors about medical malpractice, "So everybody also understands the sense of, well, if you miss something you could get sued. And the stakes are really high, so you don't want to miss anything." And although Dr. Rockstar said it directly, many participants expressed the same sentiment.

In review, the participants identified the following types of information as affecting their medical malpractice understanding: 1) memorable personal experiences, 2) medical training and experience, 3) information from external organizations, and 4) information from unspecified sources. While there were several themes apparent from the participants' interviews, there was no singular source that participants consistently cited as influential. If anything, it was striking that there was not an overarching source cited. And even more notable, doctors, who are presumably trained to think critically,

were uncritical of information they received. These topics will be covered in the following discussion section.

CHAPTER V

ANALYSIS AND DISCUSSION

> *That's the sad part, is it that those are nice, humble human beings that have been beaten down by test after test and call after call and lack of sleep and people being mean to them because they're the under level [less senior doctors] or whatever. Then they'll walk in the patient's room and not smile and not say the right thing and that patient is the entitled housewife that just had it up to here that day and said, "That's the person I'm going to go after."* – *Dr. One*

In this chapter, I explain how legal consciousness and sensemaking can be used to interpret the findings detailed in Chapters 3 and 4. As the research reviewed in Chapter 1 indicates, physicians are concerned about medical malpractice, even those in states that have passed tort reform measures. My participants are no different. They practice in Texas where we have tort reform.[40] The purpose of this chapter is to analyze the findings from my participants and indentify links to existing theories.

Review of Legal Consciousness and Sensemaking

The theory of legal consciousness was developed by sociologists to capture how individuals and groups understand legal concepts and the legal system. Ewick and Silbey (1998) explained that when researchers started studying "law and society," they focused

[40] In the United States, thirty-one (31) states have medical malpractice tort reform that limits or "caps" noneconomic or total damages. Paik et al. (2013a) estimated that 68% of Americans live in a state with damages caps. Texas tort reform caps noneconomic damages at $250,000. The other states with the same cap include: Alaska, California, Idaho, Kansas, Montana, Ohio, and West Virginia (Becker (n.d.).

on empirical work to determine if laws were accomplishing what they were intended to do, such as lower the speed limit or end the death penalty in a jurisdiction. The "law" and "society" pieces were seen as discrete and quantifiable.

The next phase in the development of the concept of legal consciousness involved researchers shifting from an examination of cause-and-effects between the law and societal effects to exploring "the presence of law *in* society" (Ewick & Silbey, 1998, p. 35). Early legal consciousness studies had sought to identify how the "law on the books" differed from "the law in action" (p. 39). Ewick and Silbey wanted to move the conversation beyond this duality to explore how people interacted with the law. They explained,

> In order to discover the presence and consequence of law in social relations, we must understand how legality is experienced and understood by ordinary people as they engage, avoid, or resist the law and legal meanings. This is the study of legal consciousness. (p. 35)

Ewick and Silbey (1998) explained that their formulation of legal consciousness is constitutive. They said, "Consciousness is not merely a state of mind. Legal consciousness is produced and revealed in what people *do* as well as what they *say*" (p. 46, emphasis original).[41]

Based on this conception as "communication" as constitutive, Ewick and Silbey (1998) developed a framework after interviewing 430 New Jersey residents about their

[41] Although this definition includes with people "do" as well as what they "say," the legal consciousness research I have reviewed has involved interviews and not observational methods. Therefore, I am interpreting what people "do" to mean what they recounted in interviews that they "did" at some point in the past or what they will "do" in the future.

daily lives and how they interacted with the law. It identified three predominant "ways of participating in the construction of legality" or three types of legal consciousness.

Ewick and Silbey's (1998) framework explains how individuals interact with the law in one of the following forms: (1) before the law, (2) with the law, (3) and against the law. As detailed above, "before the law" legal consciousness is a framing mechanism in which the law is viewed as a distant and impartial entity that operates in accord with a rational set of rules and procedures. When individuals present a "before the law" legal consciousness, they demonstrate a respect for law even when they think a particular outcome is unfair. As Ewick and Silbey explained, people who are "before the law" "defer to the law's claim to autonomy" (p. 47).

Ewick and Silbey's second frame involved actors positioning themselves as being "with the law," a form of legal consciousness in which individuals or groups view the law as a game to be played and where they strategically use the rules to their advantage. As opposed to the "before the law" orientation which treats the law as distant, a "with the law" orientation sees the law as part of life. In this legal consciousness, individuals accept the law in order to use it to their advantage. Ewick and Silbey (1998) explain that people in this orientation "seem less concerned about the law's power than about the power of self or others to successfully deploy and engage with the law" (p. 48).

Finally, when people demonstrate an "against the law" approach to legal consciousness, they feel "caught within the law" and unable to remain distanced from the law (Ewick & Silbey, 1998, p. 48). While in this orientation, individuals look for

reprieves from the law's power over them by resisting or avoiding formal laws. Ewick and Silbey (1998) explain that "diverse goals" such as maintaining a "sense of dignity and honor" or "exact[ing] revenge" can underlie this orientation (pp. 48–49).

While Ewick and Silbey's (1998) definition of legal consciousness acknowledges the constitutive nature of legality, their framework focuses on the outcomes of the orienting processes, not the processes themselves. Weick's (1995) sensemaking theory provides a perspective through which researchers can understand how actors came to hold a particular orientation in a particular situation. Weick (1995) explained, "the key distinction [from interpretation] is that sensemaking is the ways people generate what they interpret" (p. 13). Put another way, "Sensemaking is about authoring as well as interpretation, creation as well as discovery." (Weick, 1995, p. 8). Weick's sensemaking theory adds a layer of interpretation beyond the participants' legal consciousness orientation to understand how they created their understandings about medical malpractice.

All seven of the sensemaking characteristics detailed in Chapter 1 were exhibited by the participants in this study, including: relying on identity, making sense retrospectively, the productive (or enactive) nature of sensemaking, social sensemaking, how sensemaking is an ongoing process, making sense from extracted cues, and that in sensemaking, plausibility is more important than accuracy.

Interpretations Related to Research Question One

Research question one asked how physicians understand or make sense of medical malpractice and their coping strategies. As the findings above illustrate, the

following themes were identified in the responses to research question one: 1) legal knowledge ("tort reform" and "legal system"); 2) personal risk assessment ("not worried vs. it's on my mind," "heightened concerns," and "out of my control"); 3) risk reduction techniques ("communication skills," "patient management skills," and "documentation skills"); and 4) coping mechanisms ("feeling insulated" and "admitting limitations"). Below, the theories of legal consciousness and sensemaking are applied to the themes identified from the first research question.

The analysis for this section is organized based on the number of legal consciousness types present in each theme identified for research question one. The legal knowledge "tort reform" theme is reviewed first, as participants demonstrated all three types of legal consciousness within this theme. Then the personal risk assessment theme of "not worried vs. it's on my mind" is discussed because it reveals two legal consciousness orientations – "before the law" and "against the law." And finally, the remaining eight themes are covered in the final section. They each represent only one of the three legal consciousness types.

Three Legal Consciousness Orientations

Legal knowledge – Tort reform

Although the participants differed in the type of legal consciousness they articulated, all of them reported that "tort reform" was an important element of their perspective on malpractice law, in spite of the fact that the law was passed more than a decade ago. Consequently, it is important to note the overarching sensemaking technique employed by the participants before examining specific versions of legal consciousness.

This common citation to tort reform illustrated the sensemaking characteristic of extracted cues. Extracted cues are simple concepts upon which people "develop a larger sense of what may be occurring" (Weick, 1995, p. 50). However, as Weick (1995) pointed out, the same cue can have different meanings to different people. "Tort reform" had different meanings to the participants in this study and led them to be "before the law," "with the law," and "against the law" regarding this topic. Looking at the participants' sensemaking" revealed that they framed "tort reform" differently based on their practice area, their length in practice, and their experiences as expert witnesses or reviewers. However, their sensemaking was consistent within each group of similarly situated doctors (i.e., all three of the experienced OBGYNs used similar sensemaking techniques). These consistencies carried throughout the analysis; therefore, the participants are often grouped as the "more experienced OBGYNs," the "less experienced OBGYNs," and the "IMED doctors."

First, many of the participants were "before the law" when they expressed their legal knowledge of tort reform. For instance, the three less experienced, female OBGYNs quickly recounted the basics of tort reform law in Texas. They knew that there were damages caps, but they did not identify that only non-economic damages were capped. And instead of recounting the context surrounding tort reform as the three more experienced, male doctors did, all three female doctors mentioned difficulties patients might have trying to file a lawsuit following tort reform. Their focus on the issue of filing a lawsuit illustrates that their sensemaking is ongoing in nature. They chose not to

focus on the law but on how it has affected injured patients and the practicalities associated with filing a lawsuit.

Similarly, all of the IMED participants focused on the main point of tort reform in Texas – that tort reform capped damages in medical malpractice cases. Like the less experienced OBGYNs, they treated the law as a foregone conclusion and they were merely informing me about their knowledge (or in Dr. Sabrina's case, her lack thereof). Therefore, the IMED participants were discussed tort reform from a "before the law" legal consciousness.

When the experienced OBGYNs explained tort reform in Texas, they exhibited a "with the law" legal consciousness. Their words and tone were not merely informative, but were persuasive in nature and indicated that the law was passed to protect them. It was clear that the information had not come from a textbook or training. Like the less experienced OBGYNs, the experienced OBGYNs discussed that tort reform has made it more difficult to file lawsuits in Texas.[42] However, the experienced OBGYNs had a "with the law" orientation as compared to the less experienced OBGYNs' "before the law" view. Because all three experienced OBGYNs are currently working as expert witnesses in medical malpractice cases or in-house reviewers for possible medical malpractice, they are situated "within" the law. This perspective has influenced how they talked about tort reform and is in stark contrast with the manner in which the less experienced OBGYNs discussed tort reform.

[42] Notably, the experienced OBGYNs also explained that potential plaintiffs might have a difficult time filing a lawsuit, but they stated it as an acceptable consequence of tort reform. On the other hand, the less experienced OBGYNs expressed concern that the increased barriers to suit could be detrimental for patients.

The experienced OBGYNs' "with the law" lens showed that their sensemaking was identity-driven.[43] They identified themselves not only as doctors when they discussed tort reform, but also as expert witnesses or legal reviewers. These identities cast them as a part of the formal legal system. Therefore, probably without even knowing it, they spoke about tort reform in a way that was "with the law." This was much different from the less experienced OBGYNs and IMED doctors who spoke of tort reform as a fixed set of rules, or a "before the law" perspective. In fact, none of the less experienced OBGYNs or IMED doctors were expert witnesses or reviewers acting within the legal system at the time of our interviews.

The experienced OBGYNs' discussions of tort reform also illustrated the enactive nature of their sensemaking. In fact, when Dr. Obg was asked where he gathered his understanding of tort reform, he replied, "I know everything about it…I lived through it." Dr. Stork also expressed a "with the law" orientation when he said, "Legislators have been very aggressive because Texas has a very business-friendly atmosphere and that carries over into medicine as well." Thus indicating that doctors had worked with legislators in getting the law passed. This shows that the experienced OBGYNs recognized that while the legal environment influenced them, they in turn also influenced the legal environment.

Finally, the experienced OBGYNs also exhibited an "against the law" perspective when they explained how tort reform had led to more Texas Medical Board

[43] The participants in this study did not discuss the financial benefits of being an expert witness. However, it is well-established in the litigation community that medical experts are expensive. One expert witness training organization explained that in 2004, non-medical experts are paid, on average, an hourly fee of $248 while medical experts are paid an average rate of $555 per hour (SEAK, 2004).

(TMB) complaints. Dr. Six suggested that there was a behind the scenes deal between the Texas Legislature and the TMB following tort reform. This arrangement allowed the TMB to report and fine doctors for "more minor things."[44] Although this is not the formal court system, the TMB is a quasi-court system in that it an administrative agency that has authority to regulate physicians.

Dr. Six explicitly criticized the TMB process as having a "guilty until proven innocent" policy.[45] A similar claim was levied by Dr. Obg that "if there's a complaint, there's a fine."[46] Both physicians indicated that they would pay the fines or complete the punishments doled out by the TMB, but they also lacked respect for the agency. Dr. Obg actually called it a "zoo." By indicating that the TMB has a false sense of power granted to them in the wake of tort reform, the two experienced OBGYNs are exhibiting "against the law" behavior.

The experienced OBGYNs' expert witness and legal reviewer work has allowed them to move from simply standing "before the law" to acting "with the law." By being part of legal system, two of them – Dr. Obg and Dr. Six – felt comfortable criticizing the TMB. This "against the law" position illustrates again the how sensemaking is identity-driven. As Weick (1995) described, people exhibit what their identity is and then they

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[44] Ault (2012) reported on the findings in Stewart et al. (2012) that the number of TMB complaints had increased since tort reform was enacted in Texas. She quoted Dr. Russell Postier, a professor and chair of the surgery department at the University of Oklahoma College of Medicine. He said, "It appears that tort reform in Texas has done what it was intended to do" referring to the uptick in TMB complaints and a reduction in medical liability cases in the legal system.

[45] The TMB is an administrative agency and not part of the Texas court system; therefore, it is not required to follow the same legal standards.

[46] According to the TMB's website, fines are part of the informal resolution process that is used to resolve "Approximately 90 percent of all disciplinary actions that TMB takes" (Texas Medical Board, n.d.b).

are informed by how people respond to them. Both experienced doctors have been well-received in their work "with the law." This identity has given them confidence to take an "against the law" stance when they felt it was necessary.

In sum, the knowledge of tort reform theme was presented in three different orientations – "before the law," "with the law," and "against the law." Weick's (1995) theory of sensemaking helps explain how the doctors from the OBGYN and IMED groups came to these divergent legal perspectives when discussing the same legal topic. This topic was the only one that illustrated all three legal perspectives, which is interesting because all participants generally agreed that tort reform was positive legislation for doctors. The participants' practice area, practice type, and experiences informed how they "made sense" of tort reform. These same orientations and similar sensemaking characteristics are seen in the other findings from this study. However, the remaining themes present only one or two of the possible legal consciousness orientations.

Two Legal Consciousness Orientations

One theme presented two legal consciousness orientations, the "personal risk – not worried vs. it's on my mind" theme. This theme was coded as one theme instead of two separate themes because the participants who mentioned both parts did so very close in time to one another. These contradictory, almost simultaneous comments demonstrated how physicians could have two legal consciousness views regarding the same topic. Weick's (1995) sensemaking theory helps explain how participants can both hold and express contradictory views.

Personal risk – Not worried vs. it's on my mind

When asked about their personal medical malpractice risk, the participants expressed views of not being worried versus always thinking about being sued. As noted above, these opposing views were not mutually exclusive for some participants.

The experienced OBGYNs voiced both views. First, they explained that they were not particularly worried about medical malpractice, but later, each expressed that the topic was still on their minds. We will evaluate these two views in turn.

The experienced OBGYNs' first inclination, to be unconcerned about medical malpractice, represents a "before the law" legal consciousness orientation. The IMED participants also expressed this "before the law" sentiment concerning medical malpractice. However, the motivations from the experienced OBGYNs and the IMED doctors were different. The experienced OBGYNs explained that the low number of cases they and/or their partners had experienced over their long careers assuaged their fears. They also cited the low financial burden of medical malpractice. Dr Obg summarized his rational for being unconcerned with medical malpractice:

> Well, A: We have very few cases against us and B: The cost is trivial to the cost of my operations, uh …My malpractice insurance is 7 or $8000 a year…my monthly overhead is $100,000. So, you know 1.2 million of overhead, and I'm paying ...Seven thousand dollars for malpractice insurance?

On the other hand, the IMED physicians' rationale was that they were insulated from lawsuits by Regional Hospital's structure, including their in-house counsel.

While expressing their "before the law" orientation, the experienced OBGYNs

treated the law as serious. They had all had negative interactions with the law in which they felt powerless. At the same time, their continued medical experience had allowed them to distance themselves from those lawsuits and to situate the law as something that was not part of their everyday practice. Weick's (1995) sensemaking characteristic of retrospection allows individuals to reflect on past experiences in order to classify and understand current events. By relying on the retrospective nature of sensemaking, the experienced OBGYNs were able to look at their past experiences in order to manage their medical malpractice concerns. Because their experiences were discrete events, they were able to hold discrepant attitudes about them. Thus, retrospective sensemaking allowed them to refrain from constantly worrying about medical malpractice.

The IMED doctors also explained that they were not overly worried about being sued for medical malpractice, but the reasoning was different from the experienced OBGYNs. The IMED participants' lack of concern came from feeling protected by Regional Hospital and its in-house counsel. Dr. Washington said, "I work in a kind of in a protected environment at [Regional Hospital]." And Dr. Sabrina explained, "I don't, honestly pay much attention to it [medical malpractice], because I'm covered here." In discussing their medical malpractice concerns, the IMED doctors treated the law as something unknown and far away from their medical practices. They still maintained a respect for the law. Therefore, they had a "before the law" legal consciousness.

Unlike the experienced OBGYNs, they did not rely on their past experiences to form that opinion. Only one IMED participant had been sued and it was in an ancillary capacity. While another had a TMB Complaint, the others had no experiences with legal

authorities related to medical malpractice. Instead of relying on past experiences, the IMED doctors made sense of their medical malpractice risk by relying on their identities as doctors working in a protected environment. All but one IMED participant was employed by Regional Hospital, and that participant was employed by another hospital system. Their sensemaking came from the perspective that they were "inside" the organization and protected from medical malpractice. Although the IMED participants expressed the same attitude and legal consciousness orientation as the experienced OBGYNs, the rationale was different.

The same divergence can be seen in the second personal risk theme – that medical malpractice was always on some participants' minds. All six OBGYNs expressed this concern while only three IMED doctors expressed a watered down version of the same concern. This theme represented an "against the law" legal consciousness because in this orientation the participants' respect for the law has turned to fear and weariness. The rationale for coming to this orientation was different for OBGYNs than for the IMED participants.

All six OBGYNs (both the three less experienced and the three more experienced) voiced an ongoing concern about being sued. The three more experienced doctors mentioned this even after explaining just minutes before that they were not that concerned that they would be sued. The three less experienced OBGYNs were emphatic that medical malpractice risk was always on their minds. Dr. Rockstar was the most troubled and said,

It's a terrible environment to practice in, to be honest…The 'malpractice

> environment,' seriously. You shouldn't have to practice ... I don't think we should have to... to bear this weight of always being afraid you're going to get sued.

Sentiments such as these indicate why doctors have been supportive of tort reform measures to help lessen this burden.

The fact that all six OBGYNs expressed the same sentiment regarding medical malpractice concern illustrates that they chose the same information to highlight. This is the sensemaking characteristic of "extracted cues." Several OBGYNs mentioned that they received common training that was specific to OBGYNs. Dr. Six explained, "We have more vulnerability and so our… through residency and practice…the unofficial curriculum, the hidden curriculum is the malpractice thing. We learn that through, sort of, to the side. With no lectures, no formal training." This "unofficial" or "hidden" curriculum obviously stuck with the OBGYN participants and influenced their medical malpractice understanding.

Three IMED doctors also spoke about an ongoing medical malpractice concern, but it was less pronounced. Dr. Adams said there was "a little thing in the back of [his] mind that [he is] worried [he] might be sued," while Dr. Who was more general about her thoughts referring to "physicians" that have fears of being sued. These comments still represent an "against the law" perspective, but the rationale is not the same as the one used by the OBGYNs. Here, the IMED physicians do not present a common answer, but do rely on a collective understanding of medical malpractice concerns. Their comments relied more on stereotypes regarding medical malpractice instead of personal

experience. This collective sense showed that there sensemaking was social because it relied on how they interpreted medical malpractice for others not necessarily themselves. When talking specifically about themselves, the IMED doctors explained that they were protected by the Regional Hospital environment. Therefore, the three IMED doctors that expressed ongoing medical malpractice concerns were speaking about the broader, social concerns that doctors have regarding medical malpractice.

The personal risk theme regarding the level of concern participants had about medical malpractice revealed that participants had two legal consciousness orientations – "before the law" and "against the law." The experienced OBGYNs were inconsistent with their thoughts on this subject, vacillating from unconcerned to thinking about medical malpractice at all times. The sensemaking characteristics helped explain how these seemingly oppositional views are made consistent by the experienced OBGYNs. They are retrospective in looking at how overwhelming and harrowing their past legal experiences had been. At the same time, they now know that they made it through those experiences and are prepared to weather any new legal actions with better understanding and perspective.

The experienced OBGYNs also said that they think about medical malpractice "all of the time." This initial inconsistency can be resolved by one or both of the new identities the experienced OBGYNs have assumed. They are now teaching the next generation of OBGYNs through the informal and hidden curriculum. The experienced OBGYNs have also taken on roles as expert witnesses. Therefore, it is expected that all OBGYNs in this study collectively find medical malpractice to be "on their minds."

They even chose similar wording in focusing on the same extracted cues, a sensemaking characteristic that illustrates how this profession collectively talks about and teaches others about medical malpractice.

The IMED doctors presented a "before the law" view to being sued for medical malpractice because they were not very concerned. This nonchalance stemmed from their identities of being insulated by a practice area that does not get sued very often as well as being insulated by hospital organizations with extensive legal teams. The three IMED doctors that did worry about being sued spoke about it in a social way, as if talking more generally about doctors. This illustrates how sensemaking is extended beyond the individual and even the practice group to include others that have a higher probability of being sued.

In the next sections, the remaining findings are analyzed. Each theme presented only one legal consciousness orientation. I begin with the "before the law" viewpoint present in four themes.

One Legal Consciousness Orientation: "Before the Law"

The following four themes presented only a "before the law" legal consciousness: the personal risk themes "out of my control" and "heightened concerns" and the two coping themes of "feeling insulated" and "admitting limitations." The first personal risk theme, "out of my control," illustrated how participants felt that no matter how much they tried to avoid a lawsuit, they were convinced that they would be sued for medical malpractice at some point. The "heightened concerns" theme covered certain instances and patients that doctors thought were more likely to lead to a medical

malpractice lawsuit. The coping theme of "feeling insulated" was expressed by all of the participants that were employed by a large hospital structure; notably, all of the doctors employed by Regional Hospital expressed this theme. Finally, the "admitting limitations" theme was similar to the "out of my control theme." However, the "admitting limitations" theme was presented by the participants as a positive, coping strategy while the "out of my control" theme was expressed as a negative, fatalistic acceptance that a lawsuit was inevitable.

In these themes, the participants were "before the law" because they were not questioning the law but instead were accepting that they could be hauled in to court regardless of fault. As Ewick and Silbey (1998) explained, in this legal orientation individuals accept the legal rules and regulations. To be in this orientation, individuals do not always agree that the outcomes are fair. In fact, "finding themselves before the law, people express frustration, even anger, about what they perceive as their own powerlessness" (p. 47). These sentiments are present in the four "before the law" themes described below.

Personal risk – Out of my control and heightened concerns

Both personal risk themes showed that the participants felt powerless against preventing lawsuits. For the "out of my control" theme, the participants had a fatalistic outlook that they would, in fact, be sued at some point in their careers. Dr. Sabrina summarized this theme in her thoughts regarding a potential lawsuit, "I can't do anything about it. I can only take care of my patients, to the best of my ability. And if it happens, it happens. And it will happen."

The participants' acceptance that they would be sued did not coincide with their criticism of the legal system.[47] Dr. Stork even said that doctors should not take being sued personally because "it's part of the system." Another participant, Dr. Rockstar, explained, "I just kind of resolved myself that if [I am sued], I'm just going to take it as a learning opportunity to be a stronger, better person and learn how to forgive people and not be angry. And so I just kind of resolved it to that." By being "resolved" and accepting their fate, the doctors expressed a "before the law" legal consciousness.

The participants' sensemaking regarding the "out of my control" theme illustrated that sensemaking is more concerned with what is plausible than what is accurate. During our interviews, when the participants were pushed to answer why they were resigned to being sued, they were unable to point to any concrete information.[48] When they did quote a statistic, they were unable to provide a source. As discussed in the findings related to research question two in Chapter 4 above, the physicians relied more on personal experiences and medical experiences than on research to form their views regarding medical malpractice. Through their interactions with others, they have developed an understanding that they will be sued. This, to the participants, is the most plausible outcome and represents a "before the law" view.

For the "heightened concerns" theme, the participants said their risks of being

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[47] The participants did criticize the legal system as being confusing and unfair. However, these comments were temporally separate during the interviews from their acceptance that they are going to be sued. Their criticisms of the legal system present an "against the law" legal orientation and have been accounted for in the "Legal Knowledge – Legal System" theme discussed below.

[48] The participants were relying on the myth that they were going to be sued. The source of this information is discussions with others (medical and non-medical individuals), general media information, and the experiences they have (medical and non-medical). One would hope that doctors would not be influenced by myths, but it appears that they are as easily influenced as non-medical individuals.

sued increased when they had bad outcomes or when they saw certain patients.[49] With both of these concerns, the participants did not express any desire to fight the law, but accepted that their chances of being sued increased. Thus, this is a "before the law" orientation.

The participants focused on two items that caused them to have heightened medical malpractice concerns – bad outcomes and seeing certain patients. By highlighting these two items, or cues, the participants utilized the "extracted cues" sensemaking technique. First, the focus on bad outcomes seems obvious that doctors would be more concerned about medical malpractice if something goes "wrong." However, as the other personal risk theme of "out of my control" illustrated, most participants felt that they were unable to control who sued and why they sued despite their training, formal and informal, regarding avoiding lawsuits. Therefore, the fact that four doctors, two OBGYNs and two IMED physicians, chose to highlight bad outcomes illustrates that it is a cue that they extracted to elaborate on as it relates to their medical malpractice fears.

The other cue that participants chose to highlight was seeing certain types of patients. During the interviews, the participants were asked if they thought some patients were more likely to sue than others. Most participants referred back to those patients that experienced bad outcomes and became angry, but several participants instead focused on

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[49] The participants may be correct in fearing particularly bad outcomes. In studying what makes patients more likely to sue, May and Stengel (1990) determined that patients with more serious injuries were more likely to sue than the other participants. On the other hand, the patients that the participants thought would be more likely to sue (e.g., the poor and uneducated) was contradicted by the research (see Burstin et al., 1993; McClellan et al., 2012; May & Stengel, 1990).

the external characteristics of a patient such as prior lawsuits, income level, and education level.

As detailed above, research supports that prior litigation could increase a patient's likelihood to file suit again (May & Stengel, 1990); however, patients with low income and low health and legal knowledge have been shown to be significantly less likely to sue than other patients (Burstin et al., 1993; McClellan et al., 2012; and May & Stengel, 1990). When participants were asked why they selected these patients as more likely to sue, they were unable to give any sources; it was mere a bias. Therefore, the selection of these patients illustrates extracted cues as part of the participants' sensemaking process. The other two themes that presented only a "before the law" orientation are reviewed below.

Coping mechanism – Admitting limitations and feeling insulated

In the two coping mechanism themes – admitting limitations and feeling insulated – the participants accepted that they could be brought "before the law." However, the sensemaking techniques employed by the participants was different for the two coping themes.

For the "admitting limitations" theme, the participants accepted that they were human and that they could make mistakes. In doing so, the participants also explained that mistakes could lead to lawsuits. Again, the participants did not criticize the legal system when discussing possible mistakes. The participants simply stated that patients could sue them if they made a mistake. Their acceptance of the legal system's power, even over a human mistake, illustrates a "before the law" orientation. The common

sentiment again illustrates how the doctors' sensemaking is social.

The "feeling insulated" theme was present for the participants that were part of a larger institution. It is not surprising that this theme was more prevalent in the IMED participants since all but one were employed by Regional Hospital. They consistently said they coped with medical malpractice fears by relying on the hospital structure for insulation. This was a "before the law" view because they were respectful of the law, but treated it as if it was removed from the protected environment where they practiced medicine.

As described above, the IMED physicians relied on their identities as hospital employees to explain why they felt protected from medical malpractice by the hospital organizations where they worked. In reality, they can be sued as easily as any other physician. But the layers of organizational hierarchy and extensive in-house legal teams afforded by being a "Regional Hospital Physician" allowed the participants to feel insulated from legal action. The in-house counsel's legal orientation that several participants mentioned attending seemed to cement the fact that any legal issues would be taken off a physician's plate and handled by the legal department. One participant even suggested that, when possible, the legal department handled legal issues without bothering physicians. These stories from others helped solidify the physicians' identities as protected by the Regional Hospital structure. We now examine the themes that presented solely a "with the law" orientation.

One Legal Consciousness Orientation: "With the Law"

The three risk reduction themes all illustrated a "with the law" orientation. This

is the orientation we might expect because when the participants were trying to reduce their risk they were tacitly admitting that they were working within the established legal system. When asked how they reduced risk, the participants identified three skill categories: communication skills, patient management skills, and documentation skills. All three skills were presented as ways to work "with the law." In discussing these tactics, the participants accepted the boundaries presented by the law and how they could operate within the law to avoid medical malpractice lawsuits.

Risk reduction technique – Communication skills

For communication skills, the doctors talked specifically about making sure patients liked them and that they apologized for any mistakes.[50] For instance, Dr. Bento expressly stated, "I noticed if you have a really good rapport with your patients, you're less likely for [a lawsuit] to happen." Dr. One went on to say, "I don't even remember where I heard this, but if you apologize, if your patients like you, you're less likely to get sued."

In reviewing their communication skills, the participants exemplified the social nature of sensemaking. Weick (1995) explained that social influences such as "shared meaning" or "social construction" are only part of social sensemaking (p. 41). Weick (1995) explains that social sensemaking can also include coordinated actions regardless of whether or not a shared underlying meaning has been agreed upon (p. 42). In this study, most of the participants mentioned communication and/or apology without any

[50] This is one aspect of the formal and/or hidden curriculum that seems to be effective in training doctors to avoid medical malpractice lawsuits.

prompting. This suggests that the participants, both OBGYNs and IMED doctors, did have a shared meaning for what they should do to avoid being sued. But beyond this seemingly shared meaning, the participants acted in a coordinated manner by building rapport with their patients and apologizing for mistakes. Thus illustrating the social nature of their sensemaking.

Risk reduction technique – Patient management skills

The participants also presented a "with the law" orientation when reviewing patient management skills as a means to avoid medical malpractice lawsuits. The doctors focused on staying up-to-date with the current medical standard of care as well as staying within their defined medical scope. Both of these terms are legal phrases that the physicians accepted and were striving to accomplish. Dr. Fields touched upon both terms,

> If I practice within my scope of medicine…if I ask for help when I *know* I don't know the answer…and if I always do my best …. and I know when I'm [not] up-to-date on something that's changed…you take initiative to read about it. And as long as I'm doing those things, it really is hard to be negligent to the point that [I'll] be successful sued.

Therefore, this theme shows that the participants adopted an orientation of acting with the law.

The patient management skills theme shows how sensemaking is comprised of extracted cues. "Extracted cues are simple, familiar structures that are seeds from which people develop a larger sense of what may be occurring" (Weick, 1995, p. 50). The

participants who talked about patient management skills identified tactics that were related to two specific legal terms: "standard of care" and "medical scope." Despite being largely unable to determine where these terms came from (see discussion in the findings section regarding research question number two), the participants had a common understanding that they should cite these two terms. These terms led to a larger understanding that the doctors were to follow the law by staying up-to-date with the current standard of care and were to staying within their medical scope. Although the intricacies regarding the standard of care and medical scope for each specialty and each participant would differ, this extrapolation of the larger ideas from these terms shows the sensemaking technique of extracted cues.

Risk reduction technique – Documentation skills

The final risk-reduction theme of documentation skills also showed a "with the law" legal consciousness in the participants. Although the participants did not expressly state that documentation is required by law, several of them said so indirectly. For instance, Dr. One said, "Since we've entered electronic medical records…if you don't document it, it didn't happen." Several doctors also discussed how good documentation could be used to defend a medical malpractice claim.

All of the participants that spoke about documentation talked about it as a foregone conclusion, something that they had to comply with as part of their daily work. Notably, the "with the law" orientation continued even when Dr. Rockstar admitted that she does not always read what the electronic medical record (EMR) shows on the screen. She said, "And I'm not even looking at it…I'm just clicking the buttons because you

have to freaking click the buttons." Even through this frustration, Dr. Rockstar took issue with the technology and was finding a way to "click through" in order to satisfy the legal parameters that had been established. She never mentioned any desire to work against or change the legal requirements surrounding medical records.

Like the communication skills theme, the documentation skills theme again showed the social nature of sensemaking. The participants all spoke about the documentation requirement in common terms and understood it to be required. They also were frustrated by the current EMR systems. The Regional Hospital participants all used the same EMR, but the non-Regional Hospital participants had the same concerns regarding their EMR own systems. This common understanding that documentation is required and bemoaning for the current means for accomplishing documentation illustrated the social nature of sensemaking for this theme.

The three risk reduction themes are the only themes that presented a "with the law" orientation besides how the experienced OBGYNs expressed their legal knowledge of tort reform. These themes illustrated how all of the participants, regardless of practice area or medical experience, made sense in a social way and by focusing on enacted cues. We now move to the themes that presented "against the law" orientations.

One Legal Consciousness Orientation: "Against the Law"

Only one theme illustrated purely an "against the law" orientation: "legal knowledge – the legal system." Ewick and Silbey (1998) explained that in this orientation individuals are unable to remain removed from the law and find themselves "being caught within the law, or being up against the law" (p. 48). They go on to explain

that people who express this legal consciousness are often resistant, but their motivations could be diverse. This diversity helps explain how the participants in the present study could have an "against the law" legal consciousness in several themes.

Legal knowledge – Legal system

Like the first legal knowledge theme regarding tort reform described above, the second legal knowledge theme, "explaining the legal system," was just as obvious in the interview process. All participants expressed some level of distaste for the legal system, ranging from confusion and inconsistencies to extreme stress. But in this instance, all of the participants had a common "against the law" legal consciousness orientation.

This common feeling illustrates the social characteristic of Weick's (1995) sensemaking theory. In fact, Dr. Rockstar, an OBGYN demonstrated how social sensemaking includes meanings from others, who may not be present. She explained that she was stressed about even the possibility of being sued. She continued, "And the folks that I have talked to, even now in practice, who have gone through a suit, say it's one of the most horrific experiences to ever go through." She goes on to admit, "Maybe in my head, it's worse than it really is." As she has talked to others, their thoughts about medical malpractice have become her thoughts as well. This reflected stress permeated all participants without regard for their demographics. Therefore, it illustrates how the participants have made sense in a social way.

Summary of Research Question One Interpretations

The themes from research question one each illustrated at least one of Ewick and Silbey's (1998) three types of legal consciousness orientations. The first theme, "legal

knowledge of tort reform," represented all three views of legal consciousness and illustrated how one extracted cue could be interpreted differently based on practice type and experience.

Then the personal risk assessment theme of "not worried vs. it's on my mind" covered two legal consciousness orientations – "before the law" and "against the law." It showed how individuals, and in this case a group (the experienced OBGYNs), could have both orientations regarding one subject. They began by saying they were not that worried about medical malpractice because they had all survived lawsuits, they had long careers with few suits, and the cost of medical malpractice insurance was low. Then, they defaulted to the OBGYN party line that medical malpractice was "always on their minds." The less experienced OBGYNs cited this mantra as part of the "unofficial" or "hidden" curriculum that the more experienced OBGYNs were teaching them. Therefore, all OBGYNs expressed an "against the law" orientation while only the experienced ones expressed a "before the law" view. For the IMED doctors, they were overwhelmingly unconcerned about medical malpractice and saw the law as far away, which is a "before the law" orientation. Again, their reliance on protection from the larger organization explained their understanding.

Finally, the remaining eight themes covered only one of the three legal consciousness types. Four themes represented a "before the law" legal consciousness. These included the personal risk themes of "out of my control" and "heightened concerns" and the coping strategies of "feel insulated" and "admitting limitations." These four themes illustrated how the participants expressed an overall respect for the

law but viewed it as distant and apart from their medical practices. Notably, these themes were tied together in the sense that they illustrated the participants' relinquishing control regarding their ability to prevent or handle medical malpractice issues. As detailed above, they are separated into these themes because the participants expressed these ideas in different ways. For instance, "out of my control" was a negative expression that the participants felt that they would be sued, while "admitting limitations" was an expression of understanding that the participants are human and can only do what is within their control to prevent a lawsuit.

The three risk-reduction themes illustrated how the participants invoked a "with the law" orientation to avoid being sued. In this orientation, the participants employed communication skills, patient management skills, and documentation skills to comply with the legal system and its rules. Their compliance with the rules was to protect themselves and was separate from their respect (or lack thereof) of the legal system.

In fact, the participants' distaste for the legal system was apparent in the final theme of "legal knowledge – the legal system," which illustrated an "against the law" orientation. The participants expressed feelings of frustration surrounding the inconsistencies and confusion they had experienced or heard about in the legal system. I now cover the additional interpretations from research question two.

Interpretations Related to Research Question Two

Research question two asked participants to cite sources that influenced their medical malpractice knowledge. Four source categories emerged: 1) memorable personal experiences, 2) medical training and experience (including informal

communication with other medical providers), 3) information from external organizations, 4) information from unspecified sources. Some references to these themes are included in the analysis from research question one. However, not all of the influences on participants' legal consciousness and/or sensemaking are covered. The remaining analysis from each theme is detailed below.

Memorable Personal Experiences

The first theme that emerged as a source of medical malpractice influence for the participants in this study was memorable personal experiences. The participants cited three types of experiences: legal claims, patient experiences, and discussions with family members.

The first area, legal claims, brought the participants "before the law" by making them accountable to the legal system or the Texas Medical Board (TMB). However, the participants did not all have a "before the law" orientation. As discussed above, the experienced OBGYNs who had stressful experiences with early litigation had an "against the law" orientation following those proceedings. However, this group transitioned to a "with the law" orientation with regard to tort reform and managed their personal risk by taking a "before the law" perspective. This shift in legal consciousness was prompted by the sensemaking characteristic of identity as the experienced OBGYNs took on and embodied new roles as expert witnesses and reviewers in their own institutions.

Participants also talked about their experiences as patients. Dr. Sabrina, Dr. Fields, and Dr. One all stated that they thought about filing a medical malpractice

lawsuit or had a family member that considered using the legal system. Although none of them pursued a lawsuit, these views moved them, temporarily, into a "with the law" legal consciousness due to their willingness to use the legal system for their benefit. The sensemaking characteristic of extracted cues explains why these three participants chose to extract and expand on their patient experiences during our interview.

Finally, the participants reviewed discussions with family members regarding medical malpractice. Here, the participants spoke about the law as if it were at a distance, which presented a "before the law" orientation. Again, highlighting these discussions (or lack thereof in Dr. Washington's case) shows how important extracted cues were to the participants' sensemaking. I now review the three remaining themes from research question two.

Medical Training and Experience

The second theme identified from research question two was that participants were influenced by their medical training and experience. Although most of the inexperienced participants mentioned medical school or residency, the most influential training experience was recounted by Dr. Bento and Dr. Rockstar who went through the same residency program. They both recalled the residency director (called Dr. Residency, here) teaching them about medical malpractice throughout the residency. Dr. Bento said,

> So, in residency I thought it [malpractice] was huge. Everything we did, everything we were taught. I remember Dr. [Resident] was always stressing, um, you need to get this because this is what could happen. You could be sued later.

Dr. Rockstar similarly said that Dr. Residency, "taught us everything," but explained his instruction was "colored" by his previous experience in a litigious state.

This influential individual shaped both Dr. Bento and Dr. Rockstar's sensemaking "before the law" orientation in that they viewed the law as something to be respected and even feared while making medical decisions. This sensemaking again illustrates the social characteristic of Weick's (1995) sensemaking theory. They both referred immediately to Dr. Residency regarding medical malpractice and how his training style had greatly shaped their conduct as physicians. Both participants mentioned that as they got further into their own medical practices, they have stopped performing all of the cautionary procedures suggested by Dr. Residency. This shift also shows how the participants are being socialized to a new way of practicing medicine.

Another social aspect from the medical training and experience theme is that the participants did not receive a lot of legal training in their formal medical training. A few vague references were made to learning "medical/legal stuff" in medical school, and several participants mentioned learning more about legal issues in residency.

Three participants specifically said their formal training did not prepare them when it came to legal issues nor did they feel that they were taught about the business side of medicine. Dr. Six said,

> These things aren't taught in medical school. You know, we're not taught how to be businessmen, let alone how to defend – you know, even how to make a living, let alone then – to then deal with the malpractice aspect of it.

The absence of legal and business training in medical school led the participants to view

themselves as medical providers with no need to know about medical or legal issues beyond those that were passed along through the hidden curriculum. Dr. Who said, "We're scientifically based, and legal issues and money are not interesting." Many participants in this study had this mindset that they were doctors and only doctors. This illustrates how their sensemaking was identity-driven. They were comfortable being doctors and other issues did not interest them.

The eight participants employed by Regional Hospital explained that they relied on the Regional Hospital in-house counsel for legal issues. Not only did they cite their in-house counsel as a source for medical malpractice information, as explained above, they felt insulated from lawsuits. Again, the Regional Hospital participants saw their identity as singular, to be doctors within the Regional Hospital system. Their identity as doctors within a large, resource-rich hospital influenced their sensemaking.[51]

Beyond the formal training, many participants explained that they understood medical malpractice due to their interactions, which indicates that their sensemaking was social. Participants said they talked with other physicians and learned through practicing medicine. Although only a few specific conversations or interactions (like those with Dr. Residency) were mentioned, these interactions again show the social nature of doctors' sensemaking regarding medical malpractice.

Information from External Organizations

Participants did mention that they received information from external

[51] Barbour and Lammers (2007) established that the structure within which physicians practice can affect their satisfaction.

organizations regarding medical malpractice. However, it seemed as if they were socialized to cite to certain publications. For instance, most participants cited information from the American Medical Association (AMA), but their comments were general references to "emails" or "questionnaires." Their default answer was a passing reference to the AMA. The OBGYNs also cited specialty-specific publications from organizations such as the American Congress of Obstetricians and Gynecologists (ACOG). But again, these appeared to be default answers because they knew that they "should" be reading these publications.

Most participants also mentioned the Texas Medical Association (TMA). Dr. Stork relied heavily on the TMA and its publication, Texas Medicine, for his medical malpractice information. He cited the organization as a major force in getting tort reform passed in Texas. On the other hand, Dr. Six had a negative view of Texas Medicine, indicating that it was used to influence readers. He said, "If I had an article in Texas Medicine, I wouldn't really tell anybody….I mean, it's not anything to be proud of...it's not a peer-reviewed journal; it's more publicity." These opposing viewpoints illustrate how the doctors used extracted cues in their sensemaking. Many participants cited to the TMA and/or Texas Medicine. Even when the doctors had conflicting opinions the validity and purpose of Texas Medicine, they both chose to highlight the same cue.

Information from Unspecified Sources

The final theme identified from research question two was that participants were influenced by unidentified sources. For instance, six participants cited statistics about their medical malpractice risk but were unable to recall where the information came

from.[52] Another five participants said they received medical malpractice information from the media, but again, cited general sources such as "news stories." Others cited "journals," generally, and some said medical malpractice information was just "common knowledge."

These sweeping statements reiterate how doctors socially developed their understanding of medical malpractice. Most participants were able to definitively state their medical malpractice risk, with accompanying statistics, but were unable to substantiate their claims when asked. Dr. Rockstar even said, "you know, I've never seen the data on that so I can't say it's true." The answers related to medical malpractice were numbers and averages that the doctors developed from the other sources cited above.

These interpretations indicate that the participants had a complex view of medical malpractice. The participants showed a predominantly "before the law" legal consciousness throughout the identified themes. The less experienced OBGYNs only moved out of this orientation when working "with the law" to protect themselves and "against the law" when they expressed concerns about their personal risk and uncertainty about the legal system. Similarly, the IMED participants' legal orientations tracked the less experienced OBGYNs. This predominantly "before the law" orientation indicated a respect for the law, but questioned the fairness of the legal system. These feelings of uncertainty and powerlessness permeated the comments from the IMED participants and

[52] The estimates cited by the participants were not aligned with the research regarding the likelihood of being sued. For instance, Jena et al. (2011) found that across the twenty-five specialties included in their study, only 7.4% of the physicians in their study received a claim in a given year. Of those sued, only 1.6% led to the patient-plaintiff receiving a payment.

less experienced OBGYNs, which has led to an overarching fear the legal system. Even the experienced OBGYNs expressed a largely "before the law" legal consciousness. However, with their experience, they revealed more of a shift to a "with the law" and "against the law" orientation. In addition to the legal orientations in Ewick and Silbey's (1998) definition of legal consciousness, the theory of sensemaking (Weick, 1995) was applied to the findings in this study to show how the participants came to their understanding of medical malpractice.

In the final chapter, I introduce the theoretical and practical implications from this study as well as its limitations and suggestions for future research.

CHAPTER VI

SUMMARY AND CONCLUSIONS

I can't do anything about it. I can only take care of my patients, to the best of my ability. And if it happens, it happens. And it will happen. And I just have to worry about it then. *– Dr. Sabrina*

This chapter reviews both the theoretical and the practical implications from this study. The chapter then reviews limitations and future research options. Finally, it concludes with a summary.

Theoretical Implications

Several theoretical implications have been revealed through this study. First, Ewick and Silbey's (1998) three-part model can be used to understand how doctors orient themselves toward medical malpractice. Legal consciousness studies have historically looked at how individuals dealt with problems in their everyday life.[53] Scholars have more recently called for that legal consciousness research to be conducted in a specific institutional and organizational context (Silbey, 2005; Marshall, 2005). This study answers this call by studying two specific types of doctors, many of whom worked in the same medical institution. This allowed a comparison between the two specialties but also ferreted out differences in experience, which was important in this study.

[53] For example, scholars have reviewed individual's legal consciousness in the following contexts: harassment on the street (Nielsen, 2000), same sex marriage (Hull, 2003), and sexual harassment in a university setting (Marshall, 2005).

Therefore, this study shows that legal consciousness theory can be applied in a particular professional context.

A second implication for theory is that when examining the legal consciousness of individuals in a specific institution (medical practice) and a specific organization (Regional Hospital), more attention may need to be given to those institutional and organizational structures. Unlike traditional legal consciousness studies that explore how people interact with the law in their personal lives (e.g., neighborhood disputes or handling fines of a personal nature levied by the state), this study adds the specific context of a professionals working in large, complex medical organizations. Therefore, the original three legal consciousness orientations may be too simplistic in this context.

Ewick and Silbey (1998) acknowledge that organizations and institutions can influence legal consciousness. They expressly said that their conception of legal consciousness aims to "develop a cultural analysis that integrates human action and structural constraint" (p. 38). Their explication of each legal consciousness type does acknowledge that institutions and organizations can influence individuals' interpretations regarding legal issues. However, I suggest that legal consciousness should be extended to include how the institution or organization is legally oriented. For instance, in this study, Regional Hospital and its in-house counsel took steps to make the employed doctors feel "legally protected." Ewick and Silbey's (1998) framework would call this a social force influencing the participants; perhaps the framework should be expanded to include the legal consciousness produced by organizations and/or institutions.

A third theoretical implication from this study is that overlaying Weick's (1995) communicative theory of sensemaking on a legal consciousness analysis can help explain why participants' legal consciousness was divergent, even if they were located within similar institutional and organizational situations. In this study, the participants sometimes simultaneously presented different legal orientations for a topic. For instance, the experienced OBGYNs were both unconcerned about malpractice while still thinking about it "all of the time." These contradictory statements indicated that they were both "before the law" and "against the law" regarding their personal risk.

Ewick and Silbey (1998) acknowledged that one person can express more than one type of legal consciousness. They said, "[Legal] consciousness varies across time (to reflect learning and experience) and across interactions (to reflect opportunity, different objects, relationships or purposes, and the differential availability of schemas and resources)" (p. 53). They go on to explain that people can express "a multifaceted and possibly contradictory consciousness" (p. 50).

I suggest that Weick's (1995) sensemaking could help explain the situations where legal consciousnesses are divergent. As Weick (1995) stated, "the key distinction [from interpretation] is that sensemaking is the ways people generate what they interpret" (p. 13). Sensemaking captures how individuals create and discover their own understanding of a topic. By looking at legal consciousness through a sensemaking lens, the rationale for divergent legal orientations could be understood.

For example, Weick's (1995) sensemaking helped explain the different legal consciousness orientations participants expressed in the "knowledge of tort reform"

theme. The participants represented all three types of legal consciousness. Using legal consciousness theory, alone, we could have accounted for items that pushed or constrained the participants, causing them to have a specific legal orientation. But by using Weick's (1995) sensemaking theory, I purposefully sought out the sensemaking techniques that the participants were using to create their legal orientations. In this case, they all used the same extracted cue – defining "tort reform" immediately when asked about medical malpractice.

Using Weick's theory, I further examined how the participants made sense of "tort reform." The analysis revealed different sensemaking techniques even within the same practice area. For example, the less experienced OBGYNs highlighted the difficulties they saw their patients might have to filing a formal suit. They demonstrated the ongoing nature of sensemaking. While the more experienced OBGYNs acknowledged that the dynamics for filing a lawsuit had changed, they did not reflect the patients' perspective. They instead presented a "with the law" and an "against the law" orientation.

Explaining how the experienced OBGYN came to these two legal consciousness orientations shows the importance of using Weick's (1995) sensemaking theory. Ewick and Silbey (1998) stated that someone's legal consciousness can vary based on when it happens and the type of interaction. They also accounted for the same person manifesting contradictory consciousnesses. However, their theory does not provide a framework to explain how people developed their contradictory orientations. Weick's (1995) sensemaking theory fills that gap.

By evaluating the experienced OBGYN's sensemaking regarding tort reform, their rationales for divergent legal consciousnesses were revealed. First, they took a "with the law" orientation regarding tort reform. Two sensemaking techniques were identified. The first, identity, was employed as the experienced OBGYNs moved into expert witness roles and began working "with the law." The experienced OBGYNs also exemplified the enactive nature of sensemaking when they talked about living through and being part of tort reform passing in Texas. These same two sensemaking characteristics helped explain why the experienced OBGYNs moved to an "against the law" orientation when they discussed how the Texas Medical Board (TMB), a Texas administrative agency, was mishandling medical malpractice claims. By seeing themselves as involved in getting tort reform passed in Texas (enactive sensemaking) and by being part of the formal legal system as expert witnesses (identity), the experienced OBGYNS had no qualms speaking out against the TMB with an "against the law" orientation. Therefore, I suggest that Weick's sensemaking could be used to determine not only the rational for a legal orientation but also can help explain why two divergent orientations are presented.

Finally, this study illustrates how a quasi-legal entity (here, the Texas Medical Board or TMB) can be a significant part of legal consciousness. Ewick and Silbey's (1998) theory has been criticized for having "too little" to do with the law. Mezey (2001) claimed that Ewick and Silbey looked to power in social practices to find "vaguely legal concepts" (p. 153). While this criticism was not directly addressed in this study, the fact that the participants spoke about the TMB, an administrative agency, in the same manner

that they spoke about the legal system indicates that legal consciousness studies should include more than just the formal "legal system." I now move to the practical implications from this study.

Practical Implications

The present study reflects practical implications for doctors regarding medical malpractice. First, it appears that the less experienced OBGYNs are less concerned with medical malpractice and have taken tort reform as a foregone conclusion. Their more experienced counterparts were part of tort reform and, in Dr. Stork's case, part of tort reform's passage in Texas. The next generation of OBGYNs will be less likely to be politically active in this issue.

Another trend that could influence how doctors think about medical malpractice is that hospitals and other large medical centers are buying out private practices.[54] Dr. Obg talked about a large OBGYN group in his metropolitan area that had disbanded so that the doctors could be hired directly by local hospital organizations. He explained that the doctors were on salary there and they did not have to worry about the "business" side of things such as medical malpractice insurance or hiring/firing nurses or support staff.

Despite the fact that many of the participants did not recall their medical training regarding medical malpractice, I think some mention of medical malpractice, such as explaining the research regarding physicians' actual medical malpractice risk, during the formal training is necessary and could prove helpful in lessening doctors' medical malpractice concerns. Campbell (2012) has reviewed how legal education should be

[54] Gottlieb, S. (2013).

handled in medical education. She found that schools are not purposeful about how or when information is presented. She also points out that the level of legal information is inconsistent among schools, ranging from a full legal course to a passing mention of medical-legal issues. I suggest a purposeful attempt should be made to develop a curriculum that would be delivered in medical school to expose doctors in training to the basic concepts of medical malpractice. This introduction, although brief, could influence their legal consciousness and help them not feel powerless before the law.

A final practical implication is that the electronic medical record systems (EMRs) could influence how doctors try to protect themselves from medical malpractice. The present study revealed that doctors are frustrated with their EMR systems and are finding ways to work around them such as simply "clicking boxes" without even reading the content. The study participants are not alone in their frustrations. *Medical Economics* surveyed almost 1,000 physicians regarding their EMR systems and found that "67% of physicians dislike the functionality of their EMR systems" among other physician complaints (Verdon, 2014).[55] It would be interesting to explore how physicians used (or perhaps, misused) the EMR systems to protect themselves from medical malpractice. I now review the limitations present in this study.

Limitations

Although this study, like any other, has limitations, I tried to apply my knowledge and experience to overcome them. As mentioned above, I have a law degree

[55] Despite the physicians' frustrations, data is starting to come in that EMR systems are proving financially beneficial. A recent study proved that an EMR system increased revenue and reimbursements in the thirty practices where it was implemented (Howley, Chou, Hansen, & Dalrymple, 2015).

and practiced law as a litigator for several years. I then transitioned to teaching law at the undergraduate level at a large, public institution in Texas. While in my doctoral program, I have taught at the medical school at another large, public institution in Texas. Through explaining the law to others and engaging in practical and academic discussions, I have gained an appreciation for how the law is communicatively constructed. I worked diligently to keep that in mind throughout this project. Below, I address some common concerns regarding qualitative methods and some specific limitations in this study.

Using qualitative methods can lead to inherent limitations. The three main limitations repeatedly cited are: (1) potential researcher bias, (2) inability to determine cause-effect, and (3) limited generalizeability of results. Most qualitative researchers readily admit and address researcher bias. Manderson, Bennett, and Andajani-Sutjahjo, (2006) found that a researcher's age, class, and gender can influence the direction and content of interviews. The research team found that older interviewers often worked to establish a relationship with the interviewee while the younger interviewers got straight to the questions at hand. I have experienced this phenomenon first hand when I was a young attorney conducting depositions. I was so concerned with getting the questions answered that I skipped over establishing a rapport with the person I was deposing. With experience, I got better at rapport-building and ultimately got better information.

Manderson et al. (2006) also discovered that class and gender played a role in the interviews. For class, interviewers paid attention to what they wore to make sure that

they did not seem intimidating.[56] The other class-related observation was that interviewers changed their wording based on class as well. By changing their language to match the class of the person they were interviewing (i.e., using the term "mate"), the interviewer put the interviewee at ease. The other finding was that gender, of the interviewer and the interviewee, made a difference. Women interviewers provided emotionally supportive language to women interviewees. At the same time, women interviewers got the men they interviewed to open up more and provide more information. When men interviewed men, they relied on shared masculinity to gather information.

In the present study, I was close in age and class to most of my participants and the same gender as about half of my participants. I was aware of our similarities and tried to not assume that because of our sameness we shared the same sentiments. I did my best to ask and clarify in order to understand each participant.

The other two commonly-cited limitations are that qualitative studies lack causality and generalizability. First, qualitative work does not set up the same mathematical schemes found in quantitative work to determine causal effects. Qualitative work seeks to understand contextually-based perspectives of individuals; its goal is not to lead to cause-and-effect relationships. I see this as an opportunity instead of a constraint because we can gather rich, nuanced information about how individuals

[56] I thought about this dimension during my interviews as well. I tried to dress in a business-casual manner instead of wearing casual clothes or a formal suit. My appearance mirrored how my participants were dressed, which I hope helped put them at ease.

understand the world around them, which can be used to help in practical ways.[57] For instance, in the present study, many of the participants admitted that they were still "green" or "new" to the practice of medicine and that they had not been in practice long enough to have been sued. It would be interesting to re-interview those participants at time intervals such as five or ten years from now to determine if they were in fact sued and how they respond to that happening or not happening. That information could help us sculpt interventions such as training at the medical school and continuing education levels to help physicians understand and accept their medical malpractice risks.

For the final limitation that is commonly cited, that qualitative research is not generalizable, it makes sense that if we are looking for individual perspectives we might not capture the perspectives of a given population. Ellingson (2009) explains that qualitative research is usually too limited by the number of sites or the number of participants to be generalizable.

The sample size here is small, only thirteen. I found it difficult to identify doctors that would be willing to take up to an hour of their time to talk with me. Due to my contacts and personal relationship, I was able to engage the participants I had. The physicians I contacted upon the recommendation of friends or even my doctoral committee members did not return my calls. In the future, it would be advantageous to partner with an institution that would help make doctors available for interviews. At the same time, if doctors were "invited" or "forced" to participate by their institution, it could influence their answers. I could also be seen as working for the institution, which

[57] See the Practical Implications section above.

could also skew the results.

Despite the need to identify limitations in any research project, Ellingson (2009) has suggested that we are moving past the time when researchers have to be overly defensive about using qualitative methods. She suggests addressing limitations by being more transparent. She specifically calls for: (1) more clarity when defining methodological terms; (2) more complete roadmaps of the process the researcher used; (3) more recommendations for practitioners beyond the academy; and (4) support for wider variation in length of journal articles.

I have tried to offer transparency in this study per Ellingson's suggestions in order to address these limitations. I now cover the final section, future research opportunities.

Future Research

This study has raised some interesting questions for future research regarding legal consciousness, sensemaking, and how these theories apply to doctors. Several specific possible research projects are discussed below.

One key finding in the study was that the "hidden" or "unofficial" curriculum was present and important in forming the OBGYNs' understanding of medical malpractice. Academic research has actually defined three types of curriculum: (1) the formal curriculum, (2) the informal curriculum, and (3) the hidden curriculum (Hafferty, 1998). Hafferty (1998) defined the "informal curriculum" as "an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place between faculty and students" (p. 404). He went on to identify "a set of influences

that function at the level of organizational structure and culture" as the "hidden curriculum" (p. 404). I would like to compare the "formal" with the "informal" and the "hidden" curriculum regarding medical malpractice.

As for the formal curriculum during medical school and in continuing medical education, it would be interesting to determine if educating medical students and doctors about medical malpractice research would change their understanding of medical malpractice. It became apparent early in the study that the participants were not familiar with the research regarding medical malpractice in Texas. Beyond saying that things got better after tort reform in Texas, the doctors did not mention anything related to the research. Doctors require proof and data in their medical practices. In fact, there is well-known concept of "Evidence-Based Medicine" being taught in medical schools and used in the medical community. Yet, when discussing medical malpractice, the participants did not seek out information, information they had was not always accurate, and the sources they consulted were biased. This lack of reliable information could have contributed to the participants overarching "before the law" orientation. As discussed above, this orientation manifested as feelings of powerlessness. Future research could explore if more information about medical malpractice could help doctors manage their stress and anxiety regarding this issue.

It would be fascinating to see if doctors changed their medical malpractice views when they were presented with the current research regarding medical malpractice during training. If the participants in this study were given a brief overview of the statistics and research relevant to Texas physicians, would their thoughts expressed

about medical malpractice change? Of specific concern, would their thoughts regarding certain patients being more litigious than others be altered? And would any changes remain over time? A longitudinal study of physicians' ongoing medical malpractice understanding would be helpful.

Another possible research question could be to further explore the overarching "before the law" orientation in relation to quasi-legal issues such as the institution within which the doctors work and the licensing requirements they must meet. Several doctors in the present study talked about frustrations within their organizations unrelated to medical malpractice (e.g., being overworked, not being heard when voicing concerns to supervisors, and administrative changes that were confusing and time consuming). Only one doctor, Dr. Fields, explained that she fought against being overworked at her previous hospital. Interestingly, in the present study, she had less medical malpractice concerns that the other participants. This relationship is worth additional study, especially if it could lead to empowering physicians within their organizations and lead to less physician burn out over time.

Another research item that could be explored is how gender influences how view medical malpractice. In the present study, the three experienced OBGYNs were male while the three less experienced OBGYNs were female. It would be interesting to determine if gender could help explain the differences in their sensemaking.

Fourth, the doctors in this study spoke extensively about the electronic medical records (or EMR) systems they used to record their interactions with patients. The participants' comments were derogatory and were lined with frustration while at the

same time acknowledging that these systems are now necessary to receive federal funding[58]. Future research could explore how doctors might manipulate the EMRs to present the best information possible in case of a lawsuit. Research could also look at the doctors' legal consciousness regarding the underlying laws related to why these systems are required. We could also find ways to provide information regarding these laws that could help doctors manage their stress with the current system.

A fifth research direction involves the processes through which physicians come to a common understanding of terms. For instance, the doctors talked about the medical "standard of care" and their own "medical scope," but they were not pressed to explain where these terms came from. It would be interesting to determine how doctors define and construct these terms. It would also be interesting to see if these terms are constructed in a way that is similar or divergent from the way doctors in the present study made sense of medical malpractice.

Summary

This dissertation explored how doctors understand medical malpractice in Texas and what influenced their understanding. In order to understand why these concerns persist, I interviewed Texas physicians from two practice areas – obstetrics/gynecology and internal medicine. I then used an iterative approach to analyze the transcripts.

Research question one explored specifically how Texas doctors make sense of medical malpractice in Texas and their coping strategies. Coding and analysis revealed

[58] In order to receive funds from the Medicare and Medicaid incentive programs, physicians use Electronic Health Records or EHRs (Centers for Medicare and Medicaid Services, 2015).

four dominant themes: 1) legal knowledge, 2) personal risk assessment, 3) risk reduction techniques, and 4) coping mechanisms. The second research question asked physicians to identify sources that influenced their medical malpractice knowledge. They cited the following influences: 1) memorable personal experiences, 2) medical training and experience, 3) information from external organizations, 4) information from unspecified sources.

In this study, I confirmed that the participants were still worried about medical malpractice even though they were practicing in state with tort reform. I found that the participants' legal knowledge was more influenced by their personal experiences and word-of-mouth than any formal training or legal sources. By applying the theoretical concepts of legal consciousness and sensemaking, I discovered the various ways that the participants have situated themselves in relationship to the law and how they arrived at these positions. My findings suggest that legal consciousness and sensemaking can be used to understand and mitigate doctors' concerns regarding medical malpractice.

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APPENDIX A

INTERVIEW GUIDE

1. Tell me a little about yourself…(fill in other form)
    a. What is your specialty and where do you work?
    b. How long have you worked here?
    c. How long have you worked as a _____?
        i. Have you always practiced in Texas?
        ii. If not, where else have you practiced?

2. Let's talk about medical malpractice…
    a. What is the **state** of medical malpractice in Texas?
    b. What do you think your medical malpractice risk is?
    c. Do you know about tort reform?
    d. Do you know the cost of your med-mal insurance?

3. How did you determine this risk?
    a. Beyond experience…
    b. Any sources influence this definition?
    c. Any individuals influence your definition?

4. Have you ever been sued for medical malpractice?
    a. How many times?
    b. What were the facts in the case?
    c. How did you feel during the process?
    d. How did you feel following the lawsuit?
        i. If sued → Do you think that you treat patients differently after being sued?
            1. How?
        ii. If not sued → Do you think that you would treat patients differently after being sued?
            1. How?

5. Are you afraid of being sued for medical malpractice?
    a. If yes → why?
    b. If no → why not?

6. How do you cope with the fear of medical malpractice?
    a. Do you talk with others about it?
    b. Do you find resources at your professional agency or workplace helpful?

7. Do you think that your fear influences how you treat patients?

APPENDIX B

LIST OF PARTICIPANTS' DEMOGRAPHICS

OBGYNs

Pseudonym	Gender	Age	Years in Practice (post residency)	Private/ Academic	Setting	# of MDs in specialty group (# employed by hospital)	Lawsuits filed directly against MD?	Texas Medical Board claims filed directly against MD?
Dr. One	F	34	3	Both	Clinic & Hospital	> 50 (>50)	None	None
Dr. Stork	M	57	28	Private	Clinic & Hospital	3 (3)	4	None
Dr. Obg	M	62	31	Private	Clinic & Hospital	10 (10)	3	1
Dr. Bento	F	32	3	Private	Clinic & Hospital	6 (> 50)	None	None
Dr. Rockstar	F	35	5	Both	Clinic & Hospital	11 (> 50)	None	None
Dr. Six	M	60	30	Private	Clinic & Hospital	8 (> 50)	2	None

IMED

Pseudonym	Gender	Age	Years in Practice (post residency)	Private/ Academic	Setting	# of MDs in specialty group (# employed by hospital)	Lawsuits filed directly against MD?	Texas Medical Board claims filed directly against MD?
Dr. Fields	F	37	5	Both	Clinic & Hospital	20 (> 50)	None	None
Dr. Adams	M	35	5	Academic	Hospital	20 (> 50)	None	None
Dr. Washington	M	41	6	Academic	Hospital	20 (> 50)	1	None
Dr. Sabrina	F	42	6	Academic	Hospital	20 (> 50)	None	None
Dr. Who	F	39	8	Academic	Hospital	20 (> 50)	None	1
Dr. Luke	M	37	8	Both	Clinic & Hospital	5 doctors; 2 (> 50)	None	None
Dr. B	M	40	7	Private	Clinic	3 (> 50)	None	None